

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11045

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11018

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| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 17 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Leo Middle Andrew Last Ackerman | | 4. DATE OF DEATH Month October Day 6 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 23, 1878 |
| 9. AGE (In years last birthday) 81 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | 11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed | | 10b. KIND OF BUSINESS OR INDUSTRY Stave Mill | |
| 11. BIRTHPLACE (State or foreign country) Madison, Indiana | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Nicholas Ackerman | | 14. MOTHER'S MAIDEN NAME Julianne Lux | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular accident; old DUE TO (c) Cerebral and generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1960 , to Oct. 6, 1960 , that (I) (we) last saw the deceased alive on Oct. 6, 1960 , and that death occurred at 7:05 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Stella Wachslar | | 22b. DATE SIGNED 10-6-60 | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-8-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Galvary Memorial PK. | | 23d. LOCATION (City, town, or county) (State) Dairfax, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE David N. Brandt | | 25a. REC'D BY REGISTRAR Oct 10 1960 | |
| ADDRESS Dairfax, Va. | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

11011

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11046

CERTIFICATE OF DEATH

11019
Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3507 East Joppa Road | | d. STREET ADDRESS 4615 Chatford Ave. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Patricia Virginia Adams | | 4. DATE OF DEATH Month Day Year October 21, 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 6, 1924 |
| 9. AGE (In years last birthday) 36 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Continental Can | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Zacharko | | 14. MOTHER'S MAIDEN NAME Helen Stec | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-18-9592 | |
| 17. INFORMANT Jerome J. Adams | | Address 4615 Chatford Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno-carcinoma of Pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 7 5 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/11 , 19 60 , to 10/21 , 19 60 , that I last saw the deceased alive on 10/21 , 19 60 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1211 NORTHERN PKWY. BALTO. 12, MD DATE SIGNED | | | |
| ACTUAL SIGNATURE Robert W. Gebhardt M.D. | | PHYSICIAN'S NAME (Type) ROBERT W. GEBHARDT | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-25-60 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cem. |
| 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | | 24a. REC'D BY REGISTRAR DATE OCT 24 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kneass | | 24c. REGISTRAR'S SIGNATURE Arthur S. Kneass | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11026

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

| | |
|---|--|
| <p>1. Name of deceased: <u>John Doe</u></p> | |
| <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>Jan 1, 1900</u></p> | |
| <p>4. Place of birth: <u>Boston, Mass.</u></p> | |
| <p>5. Date of death: <u>Dec 1, 1950</u></p> | |
| <p>6. Place of death: <u>Home</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | |
| <p>8. Signature of physician: <u>Dr. J. Smith</u></p> | |
| <p>9. Signature of registrar: <u>John Doe</u></p> | |
| <p>10. Signature of informant: <u>John Doe</u></p> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11047

11020

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|---|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | | c. LENGTH OF STAY IN 1b 13 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (1) | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 707 W. Lexington Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle L. Last AESTOR | | 4. DATE OF DEATH Month October Day 4 Year 19 60 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH October 23, 1896 | | 9. AGE (In years last birthday) 63 yrs. | IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker | | 10b. KIND OF BUSINESS OR INDUSTRY Carpentry | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William Henry Aestor | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Hanafin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 218-01-1690 | | 17. INFORMANT Clinical Recored, VAH, Balto. 18, Md. | | Address DIVISION FORT HOWARD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) BRONCHOGENIC CARCINOMA DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 DAYS UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from Sept. 21 1960 to October 4 1960 , that (X) (we) last saw the deceased alive on October 4 1960 , and that death occurred at 8:35 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Joseph J. Cillo M.D. | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 10/4/60 | |
| 22c. PHYSICIAN'S NAME (Type) JOSEPH J. CILLO, M.D. | | | | 22d. ADDRESS VAH BALTIMORE, MD. FT HOWARD DIV | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10-7-60 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. | | | | ADDRESS Wm. Cook-Blight Funeral Home, 6009 Harford Rd. Balto. Md. | | 25a. REC'D BY REGISTRAR DATE OCT 7 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE L. K... | | | |

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CERTIFICATE OF DEATH

11021
Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | c. LENGTH OF STAY IN 1b 56 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jessups Spring Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Frances Middle R. Last Agle | | 4. DATE OF DEATH Month October Day 9 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 17, 1867 |
| 9. AGE (In years last birthday) yrs. 93 | | 10. IF UNDER 1 YEAR Months 24 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry Stauffer | | 14. MOTHER'S MAIDEN NAME Fredericka Freeburger | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Regina Eberhart | | Address Reisterstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 540 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable ruptured Peptic Ulcer DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 24 HRS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Hypertensive cardio vascular disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 8, 1960 , to October 9, 1960 , that I last saw the deceased alive on October 8, 1960 , and that death occurred at 9 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Martin E. Strobel | | ADDRESS (Street, city or town, state) 48 Main Street Reisterstown, Md. | |
| PHYSICIAN'S NAME (Type) Martin E. Strobel M.D. | | DATE SIGNED Oct 10 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 12, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons | | 24a. REC'D BY REGISTRAR Oct 13 '60 | |
| ADDRESS Reisterstown, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kinn | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11048 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11022**

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| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 | | | c. LENGTH OF STAY IN lb life | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Baltimore 22 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7541 Westfield Road | | | | d. STREET ADDRESS 1 7541 Westfield Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First RAY Middle BOWDEN Last ARGUST | | | | 4. DATE OF DEATH Month OCT Day 28 Year 1960 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9 DEC 23 | | |
| | | | | 9. AGE (In years last birthday) 36 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector | | | 10b. KIND OF BUSINESS OR INDUSTRY Rhems Manuf. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Argust | | | | 14. MOTHER'S MAIDEN NAME Margaret Fugill | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW II | | | | 16. SOCIAL SECURITY NO. 198-16-8142 | | 17. INFORMANT Mrs. Dolores L Argust (Above) | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>420.1</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion</p> <p>DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____</p> <p>DUE TO</p> <p>(c) _____</p> </div> <div style="width: 45%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 4 days</p> </div> </div> | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Jack C. Collins</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 10-29-60 | | |
| EXAMINER'S NAME (Type) Jack C. Collins | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 31 OCT 60 | | 22c. NAME OF CEMETERY OR CREMATORY Garden of Faith | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc. Balt 22 Md. | | | | 24a. REC'D BY REGISTRAR NOV 1 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. House</i> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

11048

11025

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|------------------------|--|------------------------|--|----------------------|--|-------------------------------|--|------------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 1, 1900 | | Boston, Mass. | |
| Cause of Death | | Manner of Death | | Occupation | | Education | | Religion | |
| Heart Disease | | Natural | | Teacher | | High School | | Catholic | |
| Physician | | Hospital | | Burial Place | | Date of Burial | | Name of Burial Place | |
| Dr. Smith | | St. Mary's | | Catholic Cemetery | | Jan 15, 1945 | | St. Mary's | |
| Signature of Physician | | Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Death Certifier | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11035
11023
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | | | c. LENGTH OF STAY IN 1b 3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7303 Dunbrook Court | | | | d. STREET ADDRESS 7303 Dunbrook Court | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MARION Middle FRANCES Last ATEN | | | | 4. DATE OF DEATH Month October Day 24 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 26, 1912 | |
| 9. AGE (In years lost birthday) 48 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS. Hours Min | | | |
| 10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Henry L. Kletchka | | | | 14. MOTHER'S MAIDEN NAME Marion Hunderfund | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. 063-01-6370 | | 17. INFORMANT Maurice Aten 7303 Dunbrook Court | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral CA of Both Ovaries DUE TO 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with Cerebral Infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 4 19 60 to OCT. 24 19 60 that (I) (we) last saw the deceased alive on Oct. 18 19 60 , and that death occurred on Oct. 24 19 60 at 1:45 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. PHYSICIAN'S SIGNATURE M.B. Davis M.D. | | | | 22b. PHYSICIAN'S NAME (Type) M.B. Davis, M.D. | | 22c. ATTENDING PHYSICIAN'S ADDRESS Dundalk - 22 - Md | |
| 22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22e. DATE SIGNED Oct 27 '60 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF Oct. 25, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | 23d. LOCATION (City, town, or county) (State) Brooklyn, N.Y. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md, | | | | 25a. REC'D BY REGISTRAR OCT 27 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hines | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

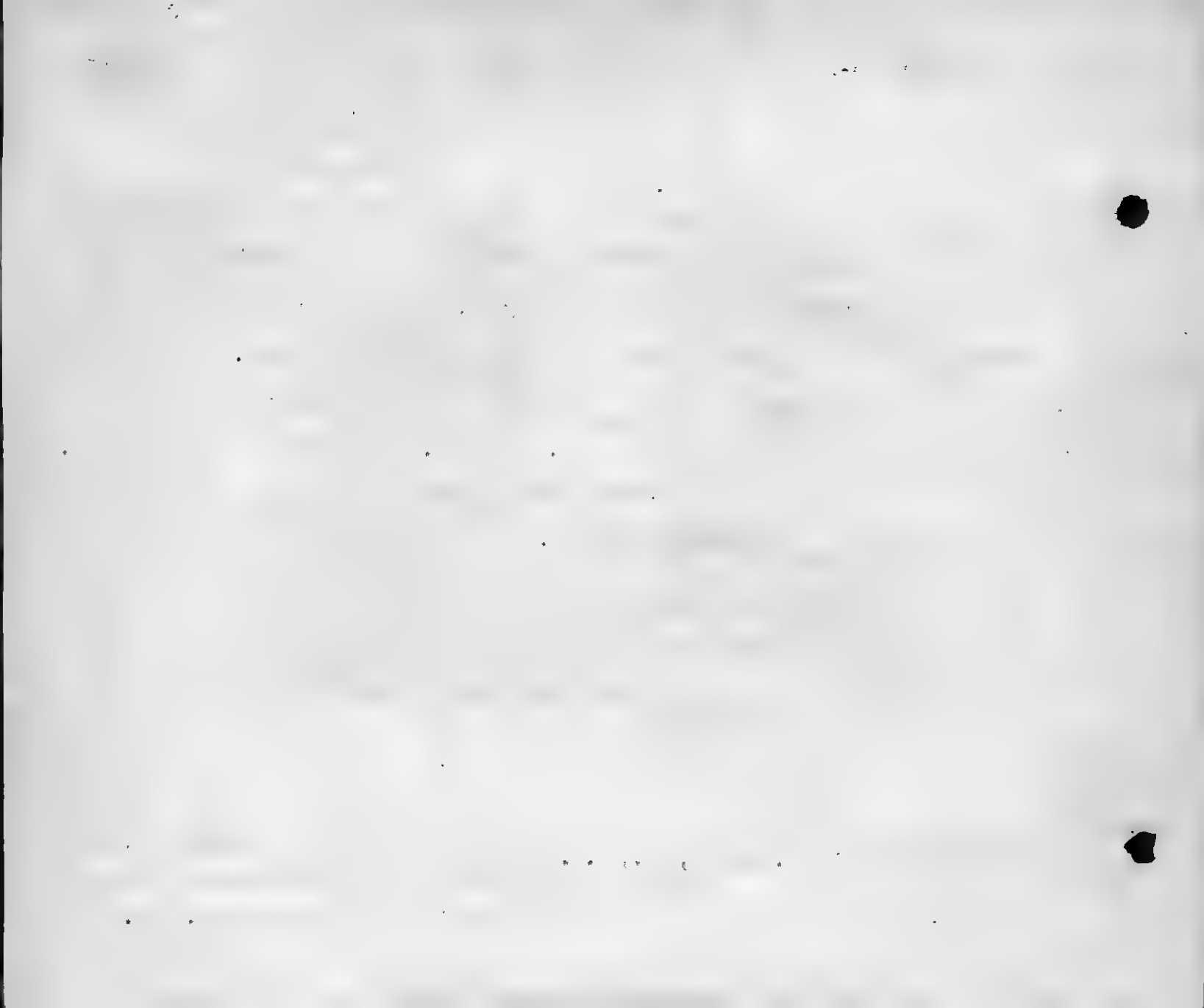
VS. AISM
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11049 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11024

Items 1, 7 Film 6274 11-4-60 at

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN b MARYLAND | |
| 3. NAME OF DECEASED (Type or print) ERWIN | | First THEODORE | | Middle BACKUS | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY OWNER BACKUS MOTORS | | 11. BIRTHPLACE (State or foreign country) DETROIT MICH. | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY? UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT MR. PAUL R. HASSENCAMP TITLE BLDG. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (b) Myocardial Infarct. (a), stating the underlying cause last. } DUE TO (c) 73001 | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town, (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr., M.D. | | M.D. William V. Lovitt, Jr., M.D. | | DATE SIGNED October 28, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 10/31/60 BURIAL | | 22b. DATE THEREOF 10/31/60 | | 22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | |
| 22d. LOCATION (City, town, or country) (State) BALTIMORE, MD. | | 24a. REC'D BY REGISTRAR DATE OCT 31 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid | | 24c. REGISTRAR'S SIGNATURE Arthur S. Kincaid | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

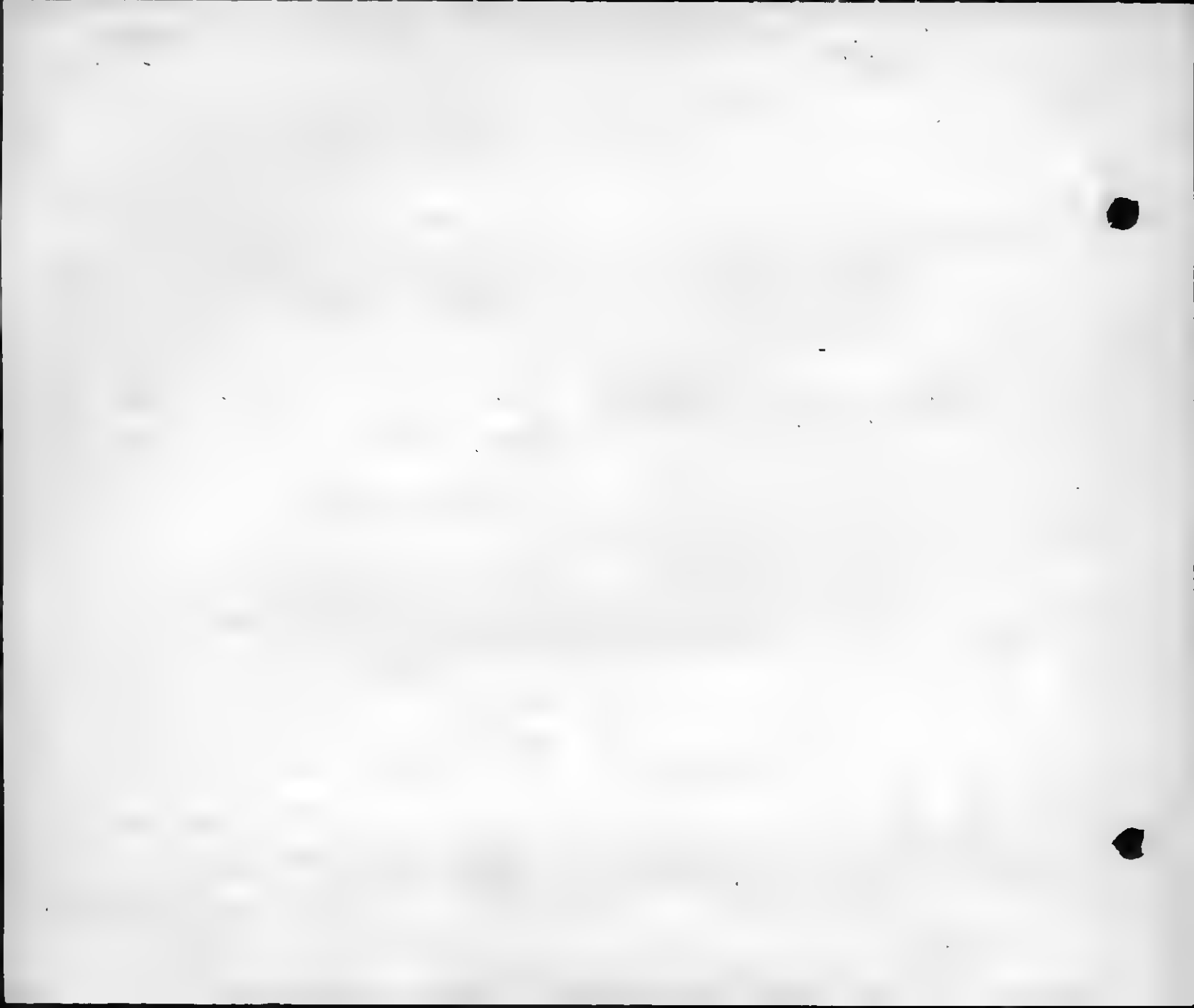
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11050

11025

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> <i>Rosewood State Training School</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OWINGS MILLS MD.</i> c. LENGTH OF STAY IN 1b RURAL and give nearest town | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>85.73</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KEYSER - W. VA.</i> d. STREET ADDRESS <i>ROUTE #3</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>KEITH</i> Middle <i>WAYNE</i> Last <i>BARB</i> | | 4. DATE OF DEATH Month <i>10</i> Day <i>22</i> Year <i>1960</i> | |
| 5. SEX <i>M.</i> | 6. COLOR OR RACE <i>W.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/8/52</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>KEYSER, W. VA.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Harding Loyal Barb</i> | | 14. MOTHER'S MAIDEN NAME <i>Irene Catherine Isen Barb</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>0</i> | |
| 17. INFORMANT <i>Medical Record, Rosewood State Training School</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>aspiration pneumonia</i> DUE TO + 911 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2/24/56</i> 19 to <i>10/22/60</i> 19, that (I) (we) last saw the deceased alive on <i>10/22</i> 1960 and that death occurred <i>10 PM</i> , from the causes and on the date stated above | | | |
| 22a. SIGNATURE <i>Hea Rankew</i> | | 22b. DATE SIGNED <i>10-22-60</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Hea Rankew MD</i> | | 22d. ADDRESS <i>Rosewood State Training School, Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <i>10/23/60</i> | 23c. NAME OF CEMETERY OR INTERMENT <i>WAXLEY</i> | 23d. LOCATION (City, town, or county) (State) <i>ALLEGHENY CO. MARYLAND</i> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Lickner & Sons</i> | | 25a. REC'D BY REGISTRAR <i>North & Pa. Ave. - Balto. 17. Md.</i> | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <i>OCT 24 '60</i> | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11026

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | c. LENGTH OF STAY IN 1b 15 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6728 Danville Avenue | | | | d. STREET ADDRESS 6728 Danville Avenue | | e. IS RES. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last DORIS LUCILLE BELCASTRO | | | | 4. DATE OF DEATH Month Day Year October 8 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-25-1912 | |
| 9. AGE (In yrs.) 48 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Daniel W. Hanns | | | | 14. MOTHER'S MAIDEN NAME Nora France | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 233-09-4331 | | 17. INFORMANT John S. Belcastro Address (Above) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE M. B. Davis | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) M. B. Davis M.D. | | | | DATE SIGNED 10/10/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-11-60 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc. ADDRESS Balt 22 Md. | | | | 24a. REC'D BY REGISTRAR Oct 13 '60 | | 24b. REGISTRAR'S SIGNATURE Carlton E. Kenna | |



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G274 11-3-60 et

11051

CERTIFICATE OF DEATH

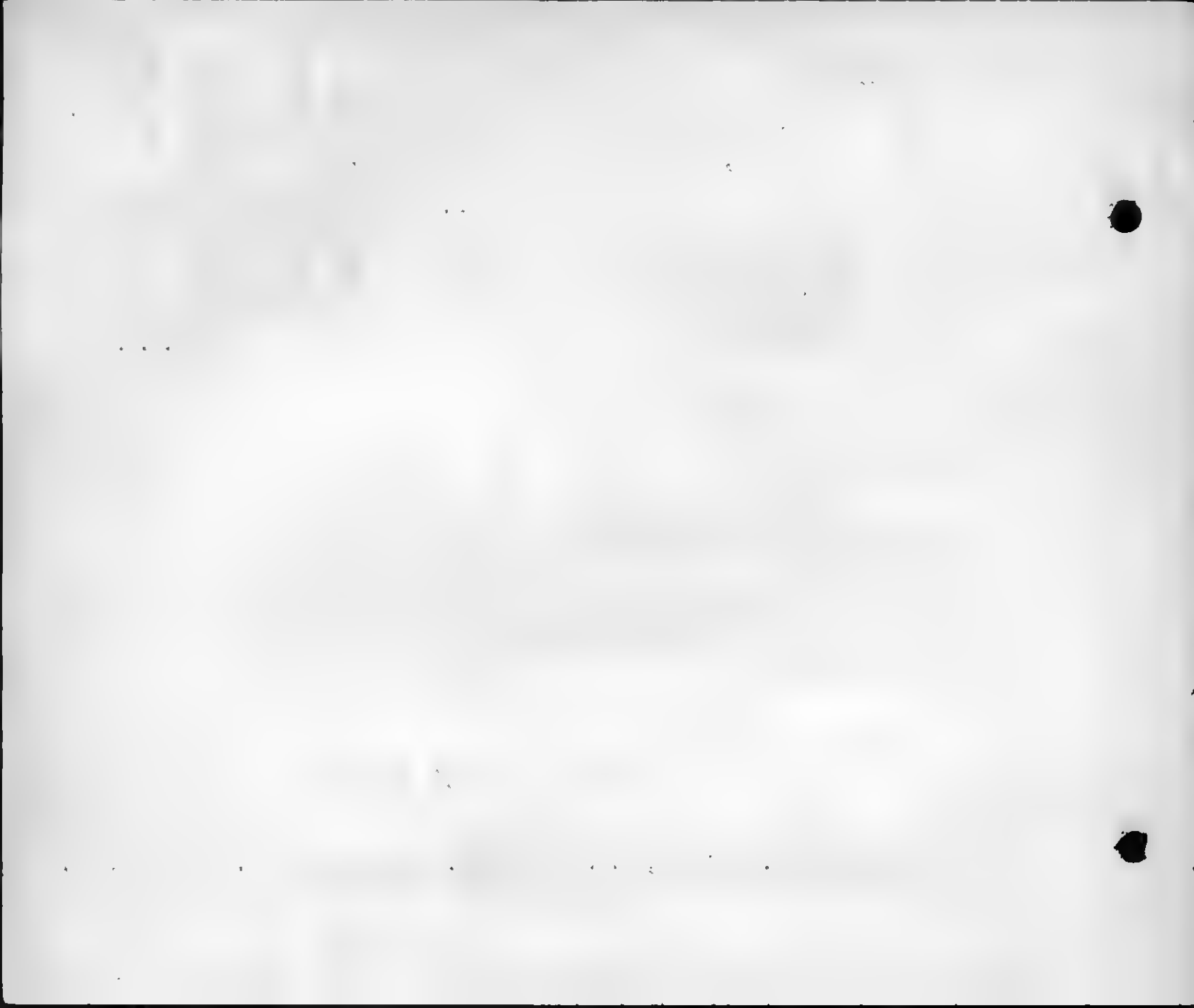
11027

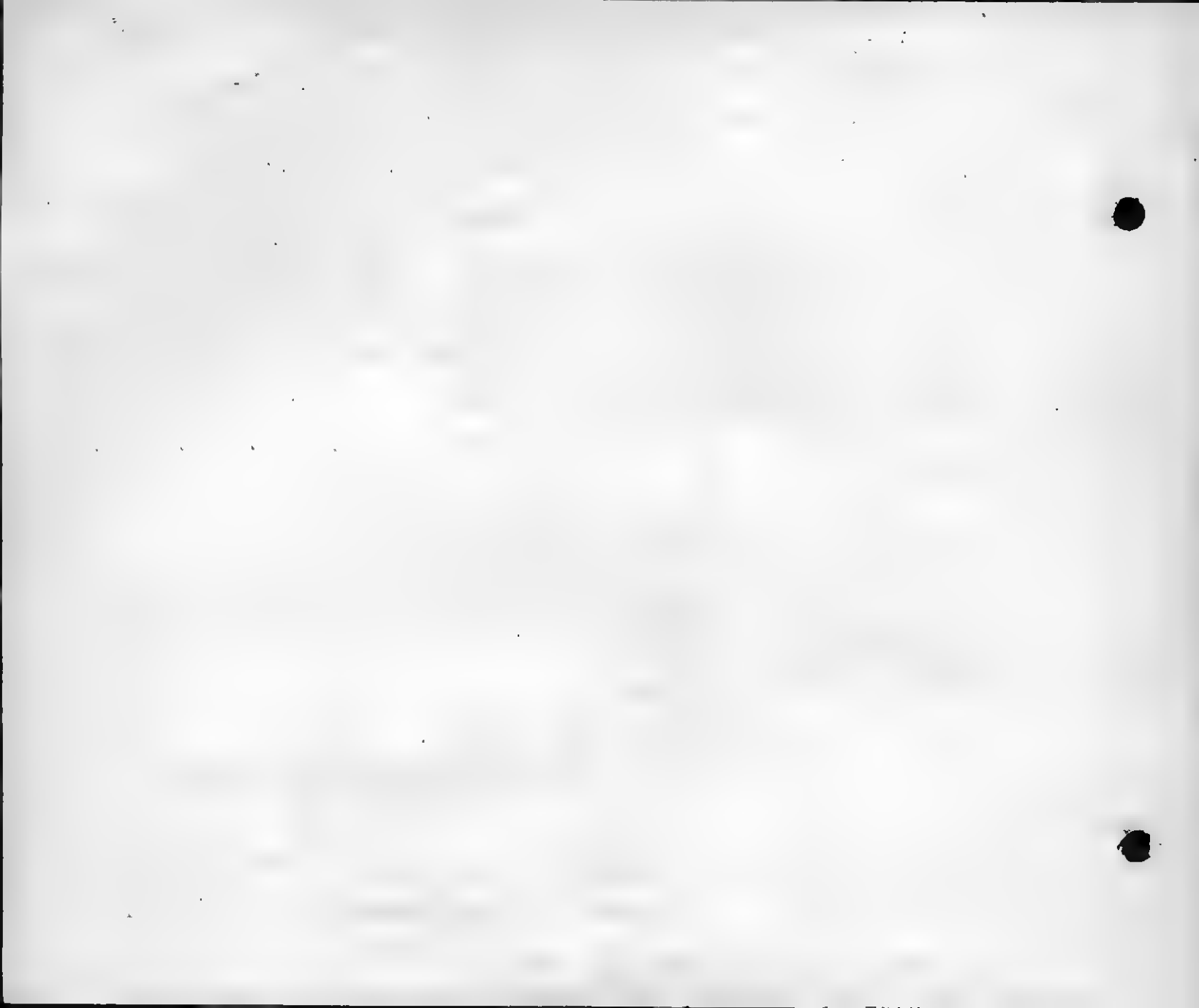
Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County <small>MARYLAND</small> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4, | | | | c. LENGTH OF STAY IN 1b 55 Towson 4, | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 318 E. Pennsylvania Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Marshall First Bell Last | | 4. DATE OF DEATH October Month 27 Day 1960 Year | | 5. SEX Male | | 6. COLOR OR RACE Negro | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 13, 1890 | | 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Private Home | | 11. BIRTHPLACE (State or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Sandy Bell | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO 412-10-8928 | | 17. INFORMANT Mary Bell - 318 E. Pa. Ave. Towson, Md. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 YRS. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL EMBOLISM - JAN 1960 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY 1 19 58 , to OCT 27 19 60 , that I last saw the deceased alive on OCT 20 19 60 , and that death occurred at 4:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Towson, Balto. Co. Md. DATE SIGNED 10/28/60 | | | | | | | |
| ACTUAL SIGNATURE T. C. Siwinski M.D. | | | | PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski, M.D. 206 W. Pennsylvania Ave., Towson 4, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/30/60 | | 22c. NAME OF CEMETERY OR CREMATORY Pleasant Rest | | 22d. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Chatman Jr. ADDRESS 1701 Mt. Culloden St. Balto. Md. | | | | 24a. REC'D BY REGISTRAR OCT 31 '60 | | 24b. REGISTRAR'S SIGNATURE Charles L. Kneass | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE
CERTIFICATE OF DEATH

11053

11029

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived immediately prior to death) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Virginia Alberta Beverly | | 4. DATE OF DEATH Month October Day 23 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 28, 1877 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 12. KIND OF BUSINESS OR INDUSTRY | |
| 13. FATHER'S NAME Cornelius Gross | | 14. MOTHER'S MAIDEN NAME Anna Harris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Beatrice Kane | | Address Winters Lane Extended | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerosis DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1960 to 10/23/60 , that (I) (we) last saw the deceased alive on 10/23/60 , and that death occurred 9:05 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE W.E. McGrath M.D. | | 22b. DATE SIGNED 10/26/60 | |
| 22c. PHYSICIAN'S NAME (Type) W.E. McGrath M.D. | | 22d. ADDRESS 1303 Frederick Rd. Catonsville Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/27/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery | | 23d. LOCATION (City, town, or county) (State) Catonsville, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Walter A. March, Jr. | | 25a. REC'D BY REGISTRAR DATE OCT 26 '60 | |
| ADDRESS 918 Druid Hill Ave. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



11054

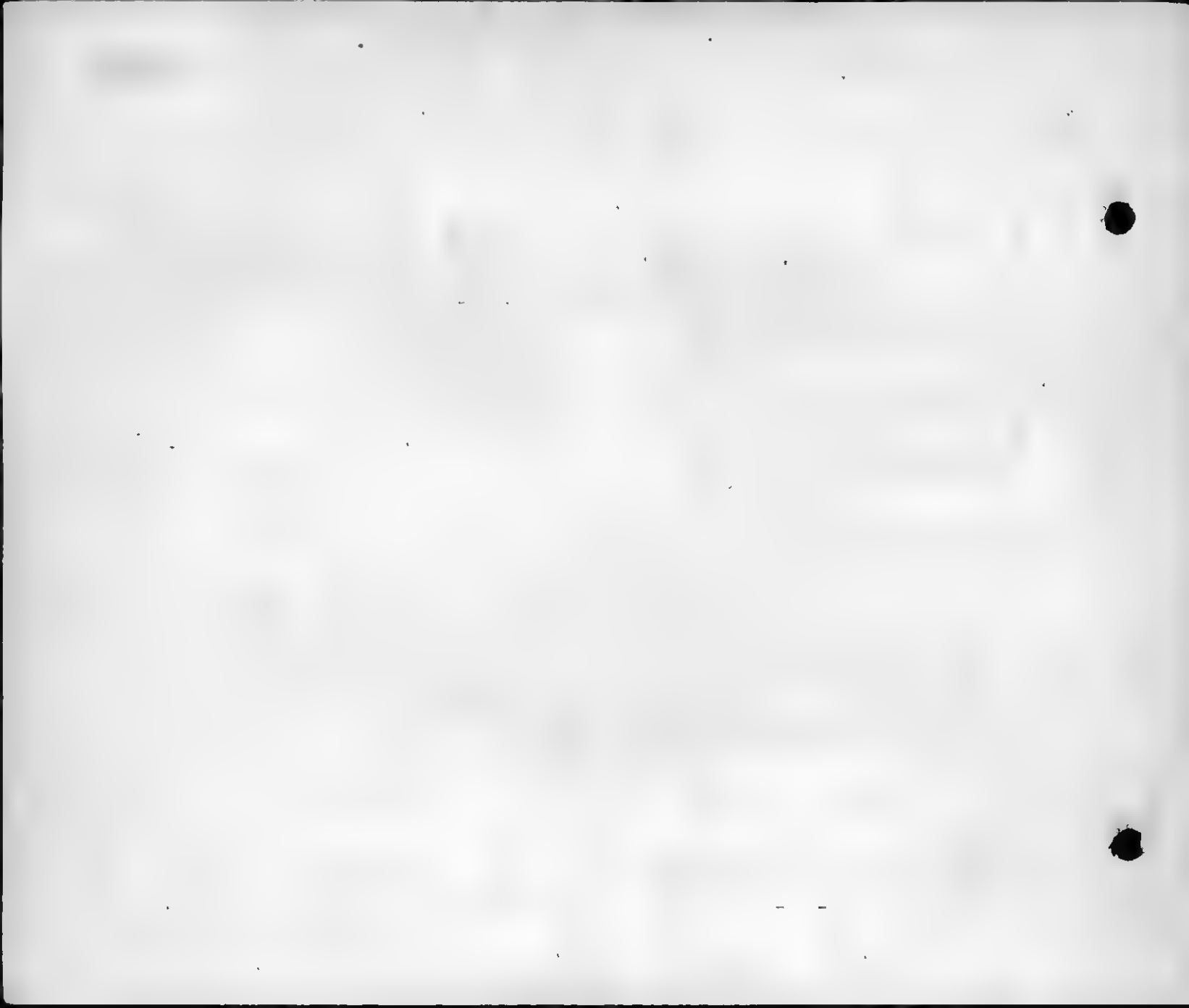
CERTIFICATE OF DEATH

Reg. Dist. No. 11030

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Son's 1860 Loch Shiel Rd. home</i> | | d. STREET ADDRESS <i>3012 Jona Terrace</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>Cecelia</i> Middle <i>Borig</i> Last | | 4. DATE OF DEATH Month <i>10</i> Day <i>14</i> Year <i>19 60</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6-26-1891</i> |
| 9. AGE (In years last birthday) <i>69</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Months Days Hours Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>George Mann</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Whittaker</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>William F. Borig</i> | | Address <i>some</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca of uterus (adenocarcinoma)</i> DUE TO (b) <i>114X</i> Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>1958</i> , 19 <i>60</i> , to <i>10/14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>10/14</i> , 19 <i>60</i> , and that death occurred at <i>3:15 P.</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Arthur E. Karfman</i> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <i>4531 Harford Road.</i> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 22b. DATE THEREOF <i>10-17-60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | 24a. REC'D BY REGISTRAR DATE <i>OCT 18 '60</i> | |
| ADDRESS <i>5305 Harford Rd.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur E. Karfman</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

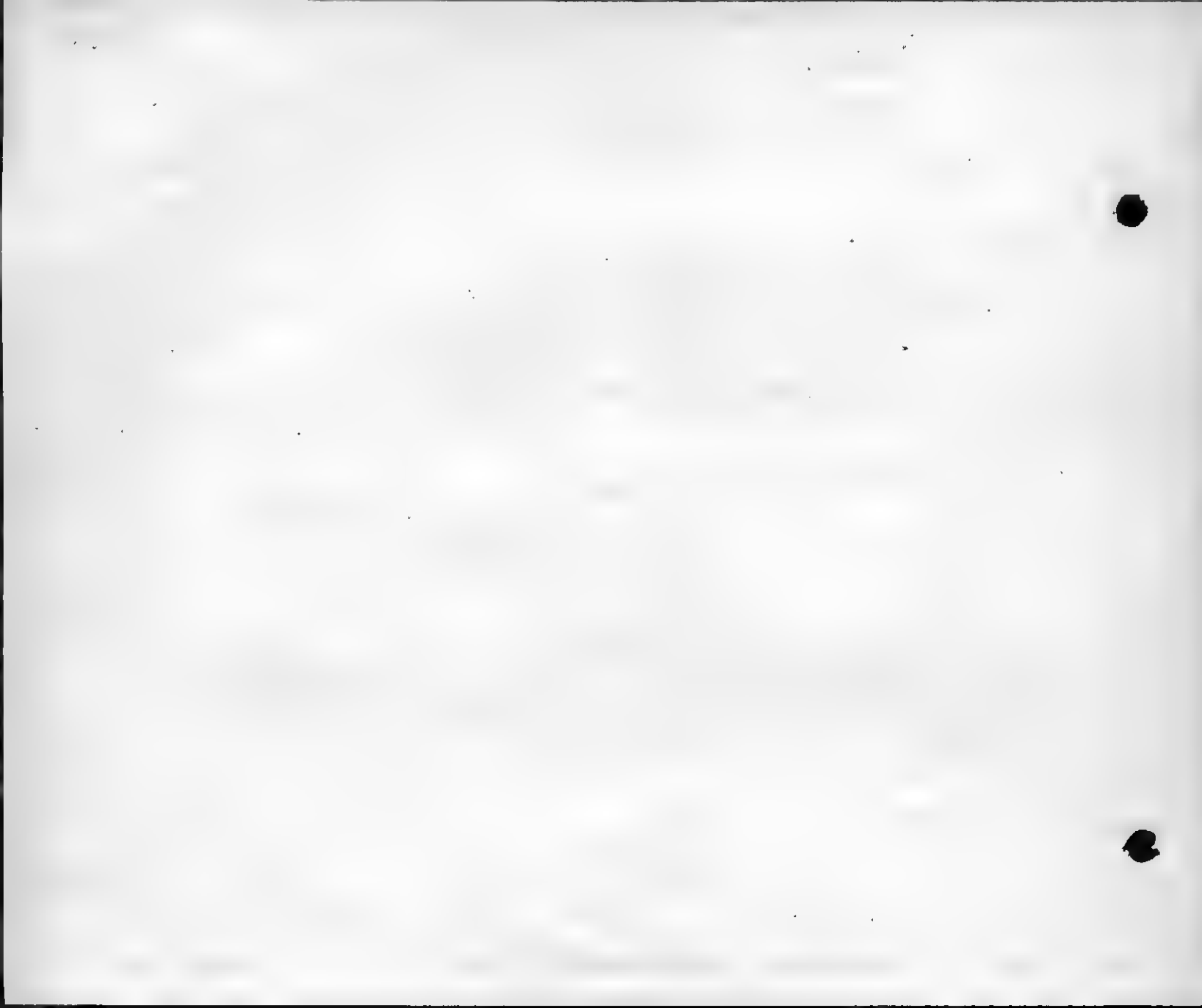
CERTIFICATE OF DEATH

Reg. Dist. No.

11055

11031

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE CO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS MD. | | c. LENGTH OF STAY IN 1b 3 YRS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First PEARL Middle HADAWAY Last BORN | | 4. DATE OF DEATH Month OCT. Day 21 Year 1960 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 13, 1873 |
| 9. AGE (In years last birthday) 86 yrs | | 10. IF UNDER 1 YEAR: Months — Days — Hours — Min. — | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 11b. KIND OF BUSINESS OR INDUSTRY — | |
| 11c. BIRTHPLACE (State or foreign country) GEORGIA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS GARLAND HADAWAY | | 14. MOTHER'S MAIDEN NAME CYNTHIA ALLEN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT SW WILLIAM BORN | | Address PIKESVILLE, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis - Chronic DUE TO Decompensating Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Arteriosclerosis (c) — | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs year year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19 — | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-21-60 to 10-22-60 , that I last saw the deceased alive on 10-21-60 , and that death occurred at 12:05 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James G. Saffell M.D. | | DATE SIGNED 10-22-60 | |
| PHYSICIAN'S NAME (Type) James G. Saffell MD | | ADDRESS (Street - city or town, state) Reston Town MD (Maryland) | |
| 22a. BURIAL, CREMATION, REMOVAL. (Specify) BURIAL | 22b. DATE THEREOF 10/24/60 | 22c. NAME OF CEMETERY OR CREMATORY OCOONEE CEM. | 22d. LOCATION (City, town, or county) (State) ATHENS GA. |
| 23. FUNERAL DIRECTOR'S SIGNATURE James H. Saffell | | 24a. REC'D BY REGISTRAR DATE OCT 26 '60 | |
| ADDRESS Westminster, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

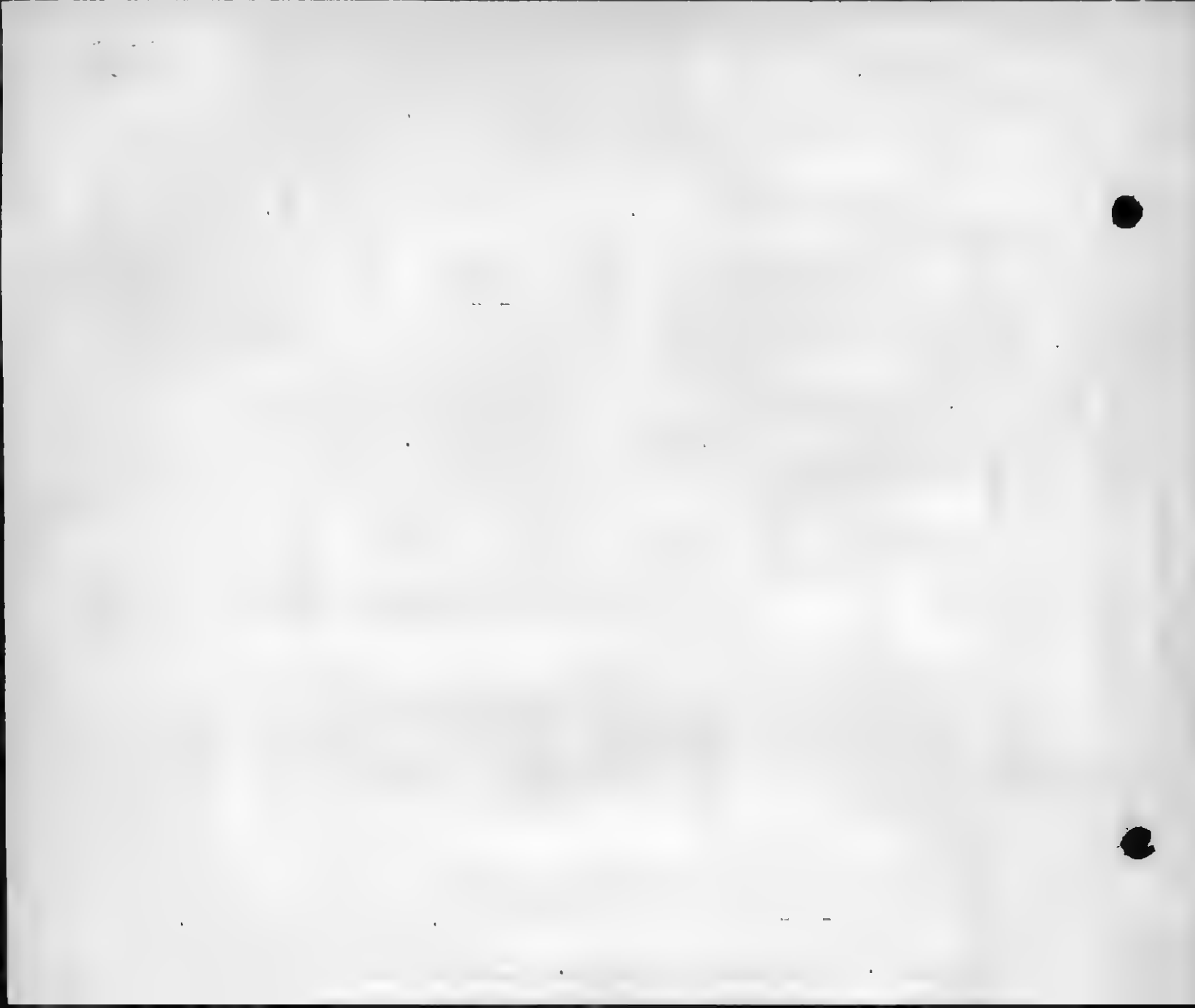
11056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11032

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bendix Radio Co., Joppa Rd.</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> | | | |
| f. STREET ADDRESS <u>8358 Oakleigh Rd.</u> | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ward</u> Middle <u>Joseph</u> Last <u>Bowers</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>19 60</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-2-1917</u> | |
| 9. AGE (In years last birthday) <u>43</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Model Shop</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Luther Bowers</u> | | | | 14. MOTHER'S MARDEN NAME <u>Margaret Greiser</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | | | 16. SOCIAL SECURITY NO. <u>215013306</u> | | 17. INFORMANT <u>Dorothy E. Bowers</u> Address <u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>10-10-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> | | | | ADDRESS <u>5305 Hartford Rd.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 10 1960</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11057

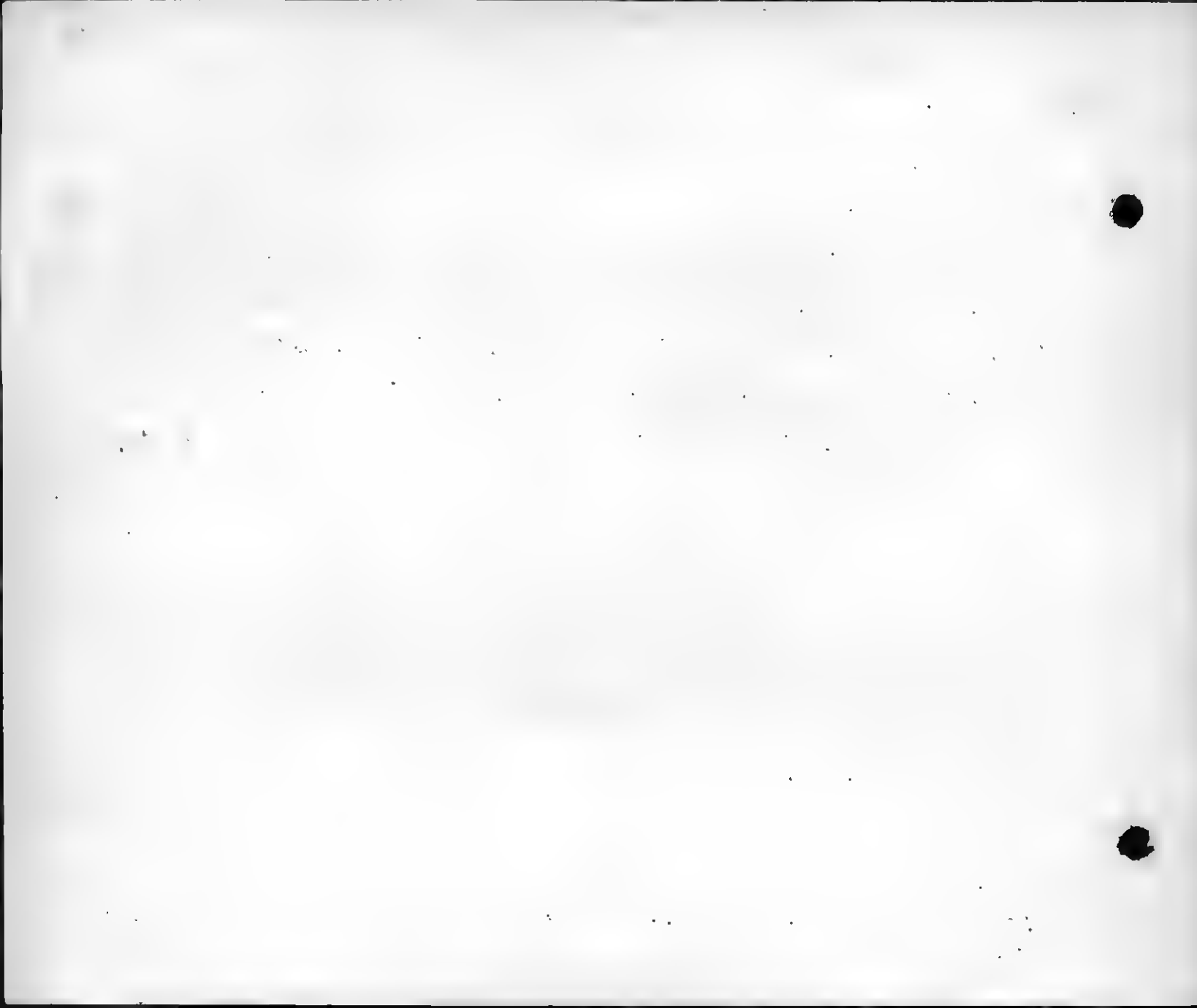
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOT BROOK</u> | | c. LENGTH OF STAY IN 1b <u>50 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE MAY BRADY</u> | | 4. DATE OF DEATH Month Day Year <u>10 - 15 1960</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-27-1885</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>DAISEY-HOWARD CO. MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>CHARLES M^{rs} DONALD</u> | | 14. MOTHER'S MAIDEN NAME <u>NAOMI ESWORTHY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>None</u> | | 16. SOCIAL SECURITY NO <u>None</u> | |
| 17. INFORMANT <u>John Brady - Carroll Co. MD (SON)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>11-34-1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Uremia</u> DUE TO (c) <u>Uremia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>1 month</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>October 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October 15</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Clarence E. Williams</u> M.D. 11904 Reisterstown Rd, Reisterstown, MD | | DATE SIGNED <u>Oct 15/1960</u> | |
| PHYSICIAN'S NAME (Type) <u>HARRISONVILLE MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/19/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>HOLY FAMILY</u> | | 22d. LOCATION (City, town, or county) (State) <u>HARRISONVILLE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Reisterstown, Md</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. Harris</u> | |
| 24b. REGISTRAR'S SIGNATURE | | DATE <u>OCT 18 '60</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11058
CERTIFICATE OF DEATH

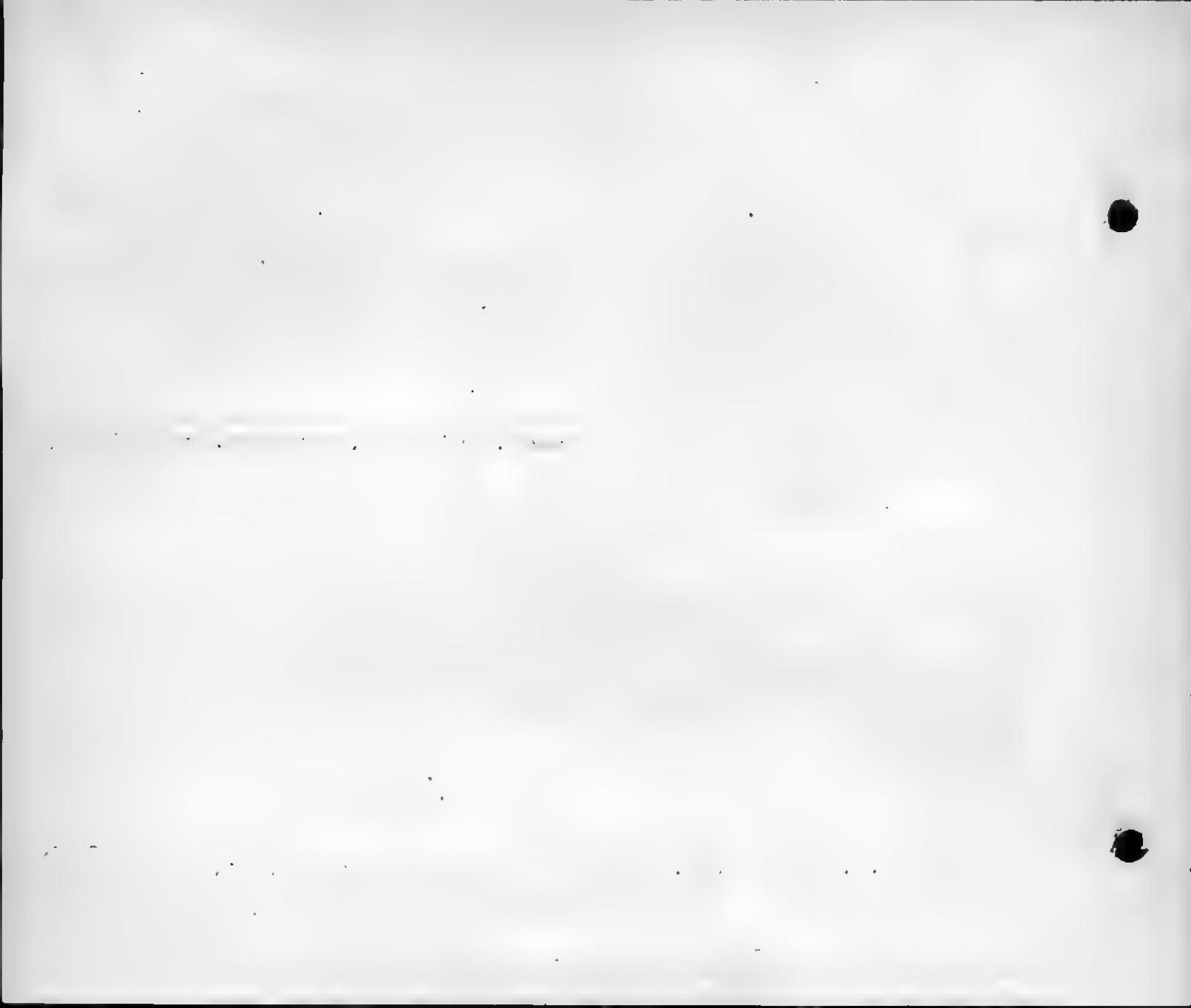
11034

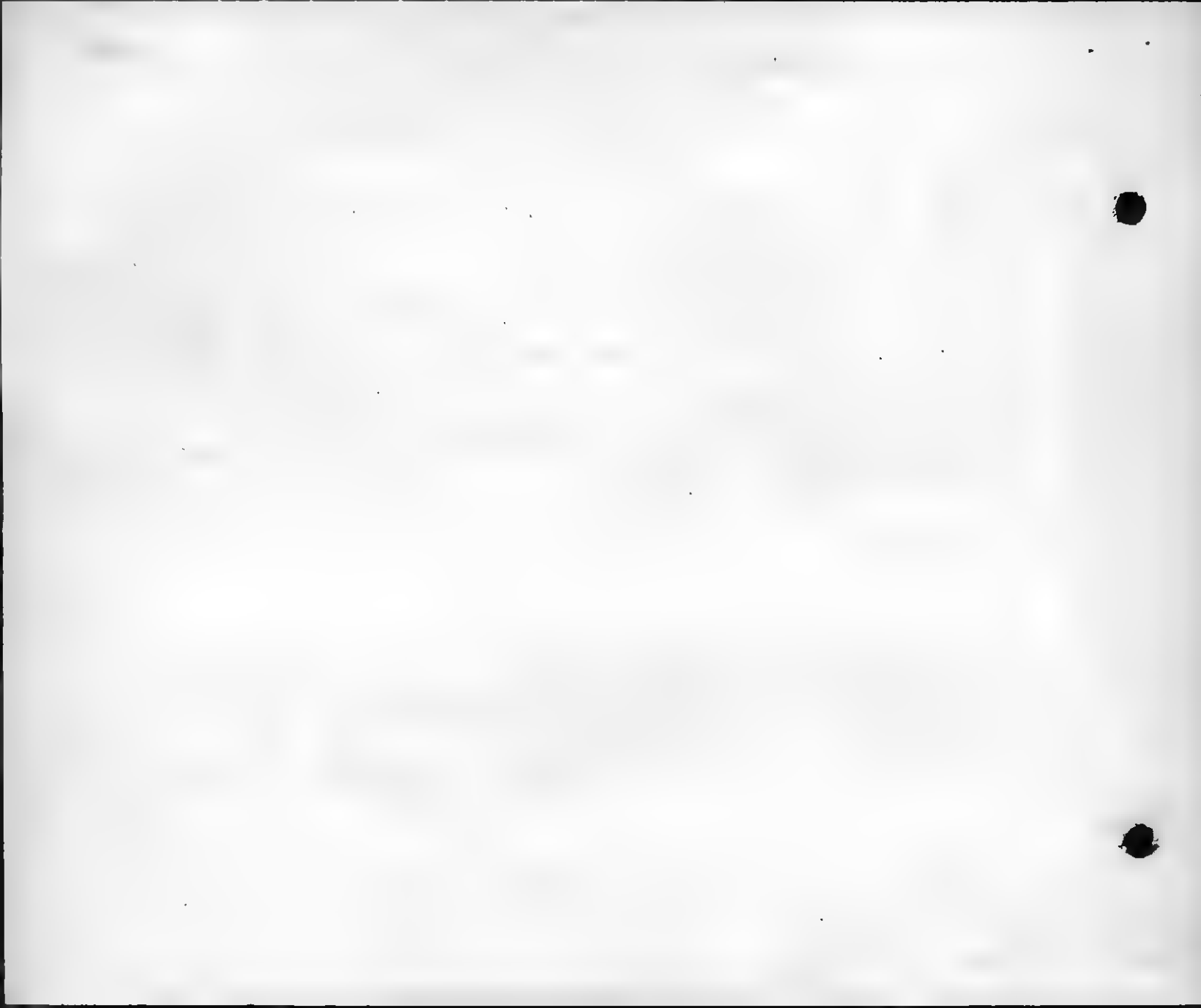
Reg. Dist. No.

| | | | | | | | |
|---|--|--|-------------------------|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Roberts Ave. | | | | d. STREET ADDRESS 2 Roberts Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle Brooks Last Brooks | | | | 4. DATE OF DEATH Month Oct. Day 29, Year 19 60 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 9, 1905 | |
| 9. AGE (In years last birthday) yrs 55 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Walter Neal | | | | 14. MOTHER'S MAIDEN NAME Jennie | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mary A. Matthew 2 Roberts Ave. Catonsville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 Months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-8-60 , 19 60 , to 10-29-60 , 19 60 , that I last saw the deceased alive on 10-29-60 , 19 60 , and that death occurred at 10:30 M, from the causes and on the date stated above. P.M. ADDRESS (Street, city or town, state) 57 Winters Lane Catonsville, 28. Md. DATE SIGNED 10/29/60 | | | | | | | |
| ACTUAL SIGNATURE C.F. Maloney M.D. | | | | DATE SIGNED 10/29/60 | | | |
| PHYSICIAN'S NAME (Type) C.F. Maloney, M.D. | | | | Catonsville, 28. Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/1/60 | | 22c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery | | 22d. LOCATION (City, town, or county) (State) Catonsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Halstead & March 918 Druid Hill Ave. | | | | 24a. REC'D BY REGISTRAR DATE OCT 31 '60 | | 24b. REGISTRAR'S SIGNATURE <i>William S. Kneass</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11037

11060

| | | | | | | | |
|--|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE HALL MD</u> | | | | c. LENGTH OF STAY IN 1b <u>10 YEARS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WHITE HALL MD</u> | | | | e. STREET ADDRESS <u>WHITE HALL MD</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian C Chiseweth</u> | | | | 4. DATE OF DEATH Month Day Year <u>Oct 2 1960</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 9, 1883</u> | 9. AGE (In years last birthday) yrs <u>77</u> | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>NATHAN COLE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZA L. HOPKINS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>10 12 12</u> | | 17. INFORMANT <u>HOWARD CHISEWETH</u> | | Address <u>114... FA</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Generalized arteriosclerosis & hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <u>Nov. 1958</u> to <u>29 Oct. 1960</u> , that I last saw the deceased alive on <u>26 Oct. 1960</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Reginald B. Gemmill</u> | | M.D. | | ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u> | | DATE SIGNED <u>28 Oct. 1960</u> | |
| PHYSICIAN'S NAME (Type) <u>Reginald B. Gemmill</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>OCT 31 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MORRISDALE</u> | | 22d. LOCATION (City, town, or county) (State) <u>FAIRFAX VA</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Funeral Home</u> | | ADDRESS <u>7701 Belair Road</u> | | 24a. REC'D BY REGISTRAR <u>NOV 7 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11038

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11038

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | | | |
| c. LENGTH OF STAY IN 1b <u>12 yrs.</u> | | | | d. STREET ADDRESS <u>5517 Link Ave</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5517 Link Ave.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Clark</u> Last <u>Clark</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 14, 1888</u> | |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>James Clark</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katherine Mullin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO <u>None</u> (If yes, give war or dates of service) | | 17. INFORMANT Address <u>Gertrude Fritz 5517 Link Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>Generalized Arteriosclerotic Cardiovascular Disease</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>1960</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/10/58</u> to <u>10/9</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>10/9</u> 19 <u>60</u> , and that death occurred <u>9:40</u> AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Joseph G. Laukaitis</u> | | | | 22b. DATE SIGNED <u>10/9/60</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Joseph G. LAUKAITIS MD</u> | | | | 22d. ADDRESS <u>679 Washington Blvd</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/12/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | | 23d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase Inc 1328 Sulphur Spring Rd</u> | | | | 25a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 13 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u> | |



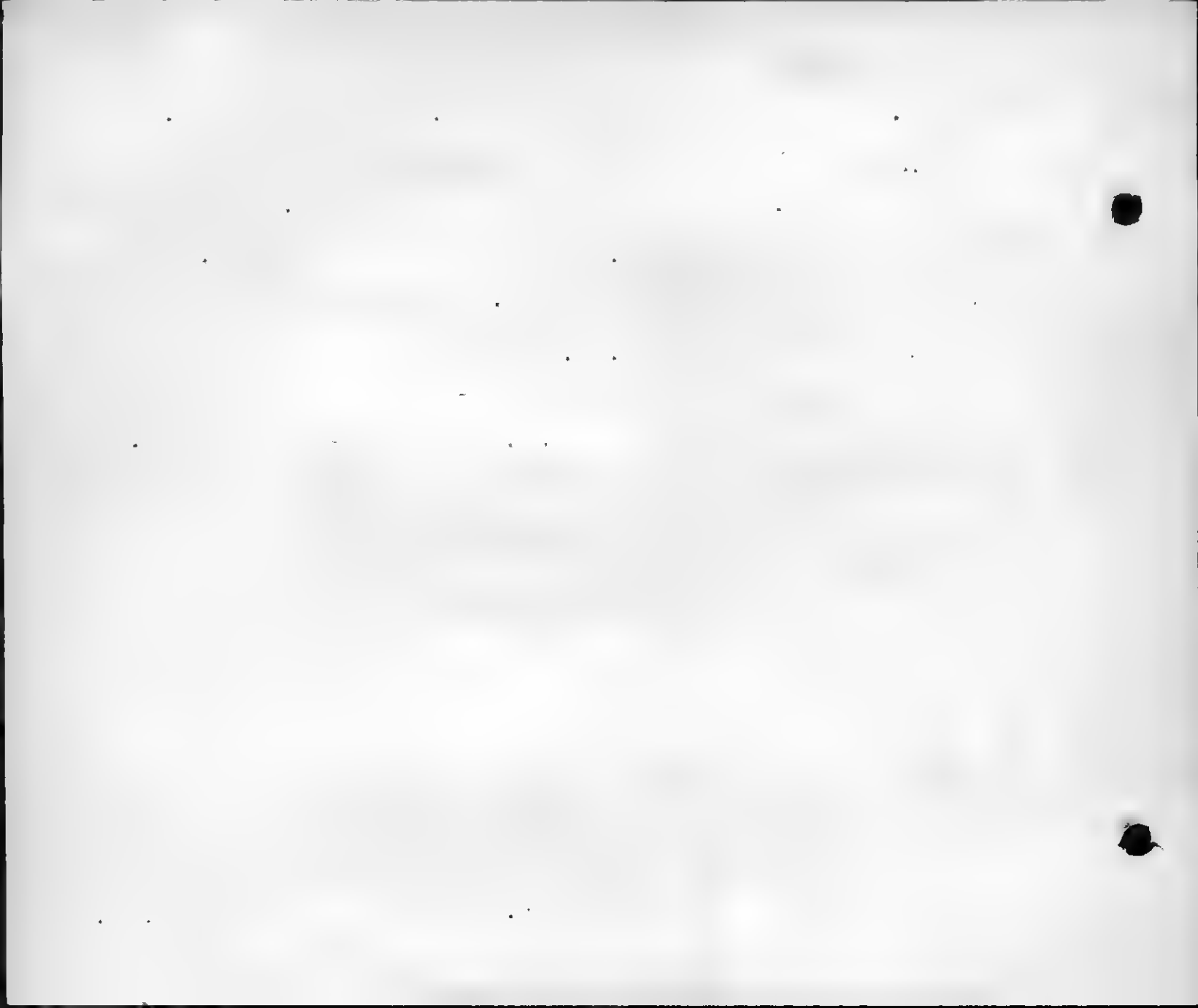
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11039

11061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|---|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7 | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7 | | | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle R. Last CLEAR | | | | 4. DATE OF DEATH Month Oct. Day 19 Year 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 18, 1885 | 9. AGE (In years last birthday) 75 yrs. | 10. IF UNDER 1 YEAR Months 7 Days 19 Hours 19 Min. | 11. IF UNDER 24 HRS Months 7 Days 19 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY C & P Tel. Co. | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? — | |
| 13. FATHER'S NAME Clear | | 14. MOTHER'S MAIDEN NAME — | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | |
| 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Mr. M. Clyde Murphy - 3608 Croydon Rd. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (1) - Arteriosclerotic Heart - Disease DUE TO (b) - Cancer of Prostate - DUE TO (c) - Paget Disease - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 1 yr. 2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month. 19 Day. 19 Year. 1960 Hour a. m. 10 p. m. 10 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 25, 1940 to Oct. 19, 1960 , that (I) (we) last saw the deceased alive on Oct. 18, 1960 , and that death occurred at 3 AM , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Earl L. Chambers | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 10/19/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Earl L. Chambers - | | 22d. ADDRESS 4108 Liberty Hts. Ave. Balto.-Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 10/22/60 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | 23d. LOCATION (City, town, or county) (State) Pikesville, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE William J. Lickens - Balto. Md. | | | | 25a. REC'D BY REGISTRAR DATE OCT 21 60 | | 25b. REGISTRAR'S SIGNATURE William J. Lickens | |



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

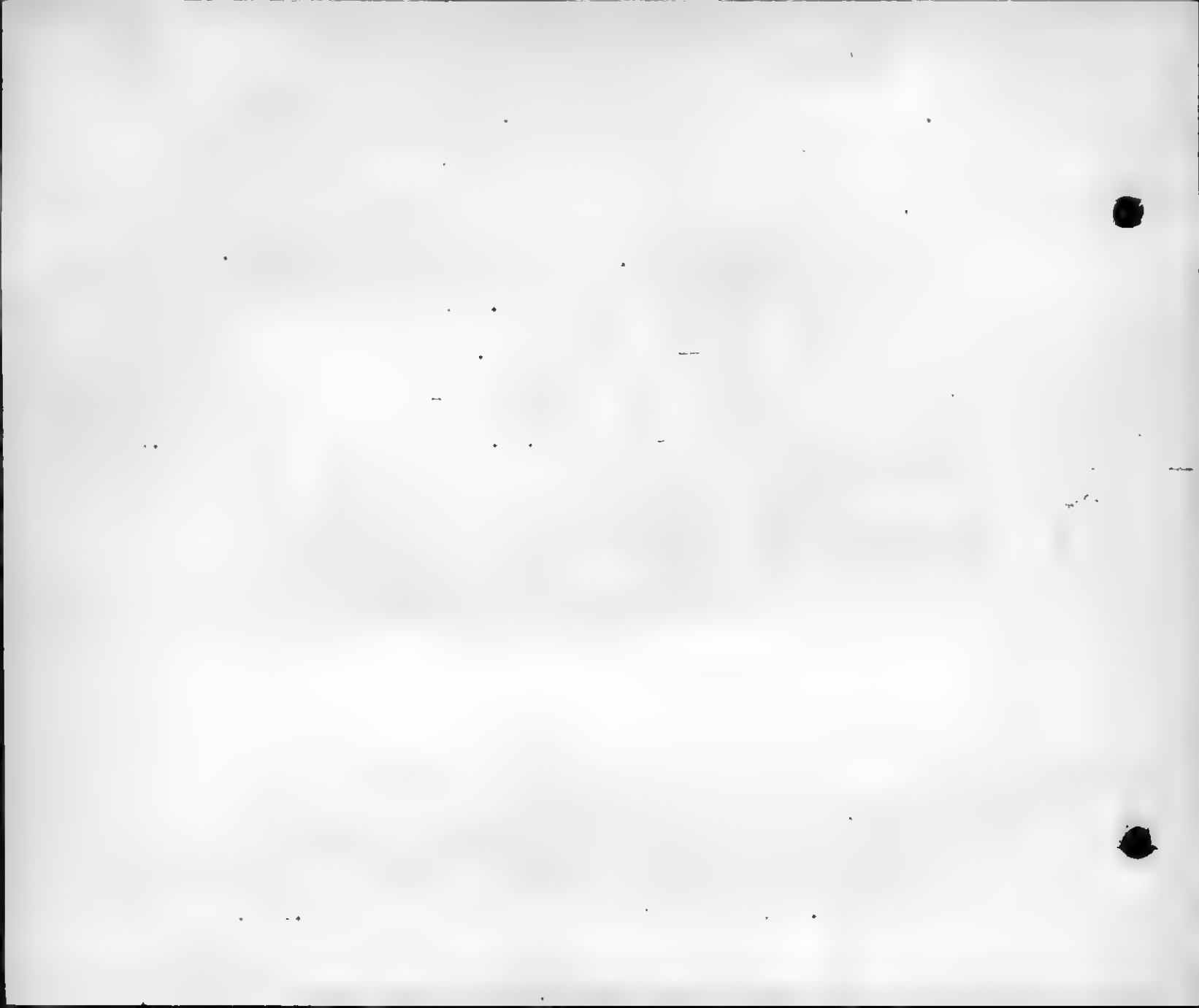
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ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11062

11041

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Balto. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 | | | | c. LENGTH OF STAY IN 1b Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcoast Nursing Home | | | | d. STREET ADDRESS formerly of 5007 Ivanhoe Ave. | | | |
| 3. NAME OF DECEASED (Type or print) First MARGARET Middle H. Last COARD | | | | 4. DATE OF DEATH Month Oct. Day 12, Year 19 60 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 15, 1879 | |
| 9. AGE (In years lost birthday) 81 yrs | | 10. IF UNDER 1 YEAR Months 81 Days 12 Hours 19 Min 60 | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? Md. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | | |
| 13. FATHER'S NAME Carl Humberg | | | | 14. MOTHER'S MAIDEN NAME Maria - | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO 211-12-0855B | | 17. INFORMANT Mrs. W. Kenneth Root - 37 Burke Ave., Towson 4 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4-2-1 IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic C.V. Disease DUE TO (c) 5 yrs. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 9/9/60 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 10, 1960 to Oct 12, 1960 , that (I) (we) last saw the deceased alive on Oct. 15, 1960 , and that death occurred 5:50 AM , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Carl F. Benson M.D. | | | | 22b. DATE SIGNED Oct 14 '60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Carl F. Benson M.D. | | | | 22d. ADDRESS 5111 York Rd. Balt. 12 Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 15, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | | 23d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE William J. Lukin | | | | 25a. REC'D BY REGISTRAR Oct 14 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 3273 10-26-60 et

CERTIFICATE OF DEATH

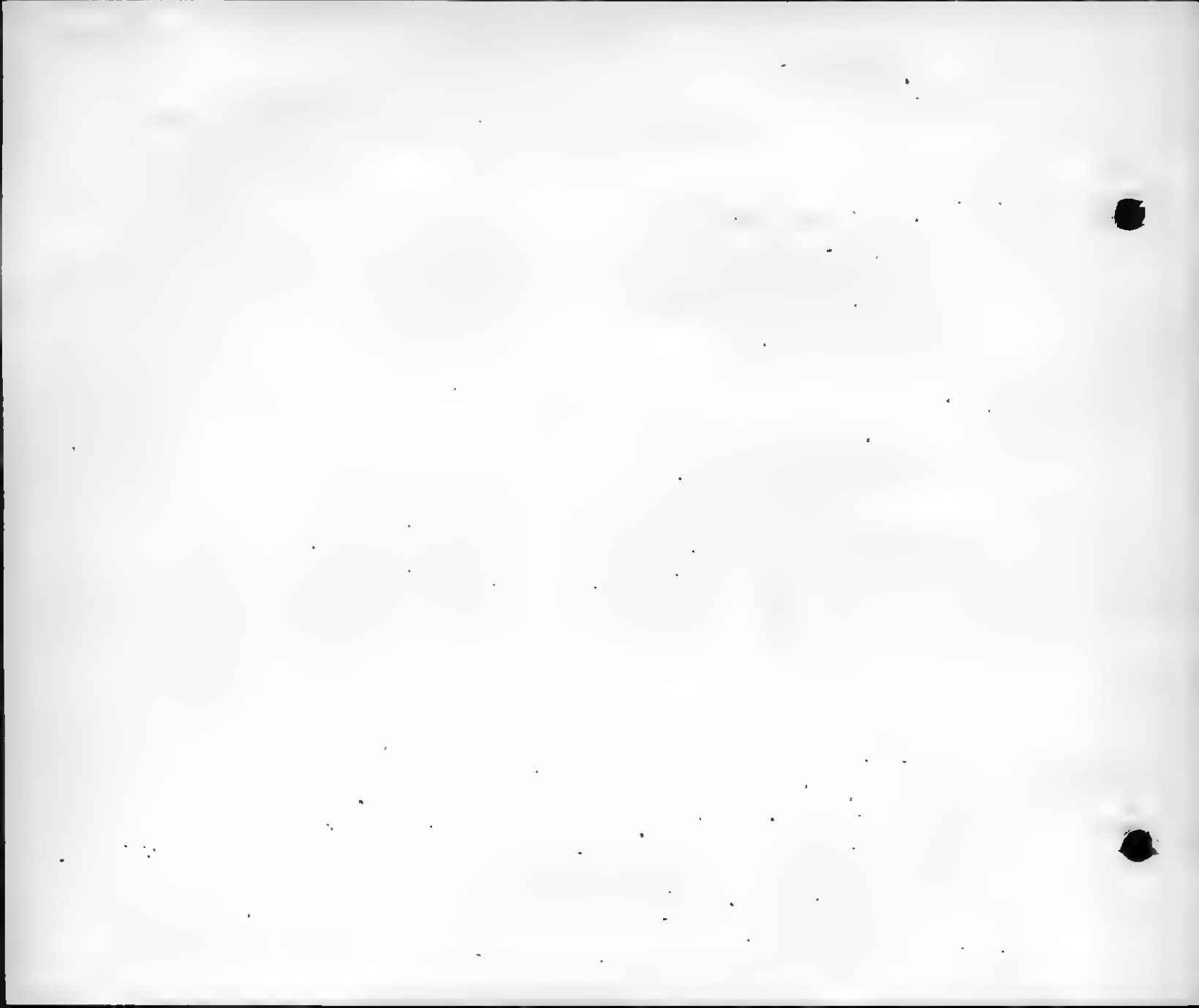
Reg. Dist. No.

11042

11039

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landsdown</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3107 Hammond Ferry Rd</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landsdown</u> d. STREET ADDRESS <u>3107 Hammond Ferry Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Otto Scott Colder</u> | | 4. DATE OF DEATH Month Day Year <u>Oct 17 1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 27-1890</u> |
| 9. AGE (In years last birthday) <u>70</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U. S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>John Colder</u> | | 14. MOTHER'S MAIDEN NAME <u>Ann Brown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u> | | 16. SOCIAL SECURITY NO. <u>217-07-3974</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General debility</u> DUE TO (c) <u>Carcinoma of mouth</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1959</u> , 19 <u> </u> , to <u>Oct 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 16</u> , 19 <u>60</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1010 Locust St</u> DATE SIGNED <u>Oct 18 60</u> | | | |
| ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D. <u>1010 Locust St</u> | | | |
| PHYSICIAN'S NAME (Type) <u>GEORGE S. M. KIEFFER</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 22b. DATE THEREOF <u>Oct 20-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto. City</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. J. Schuchman</u> ADDRESS <u>2101 Frederick Ave</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u> |

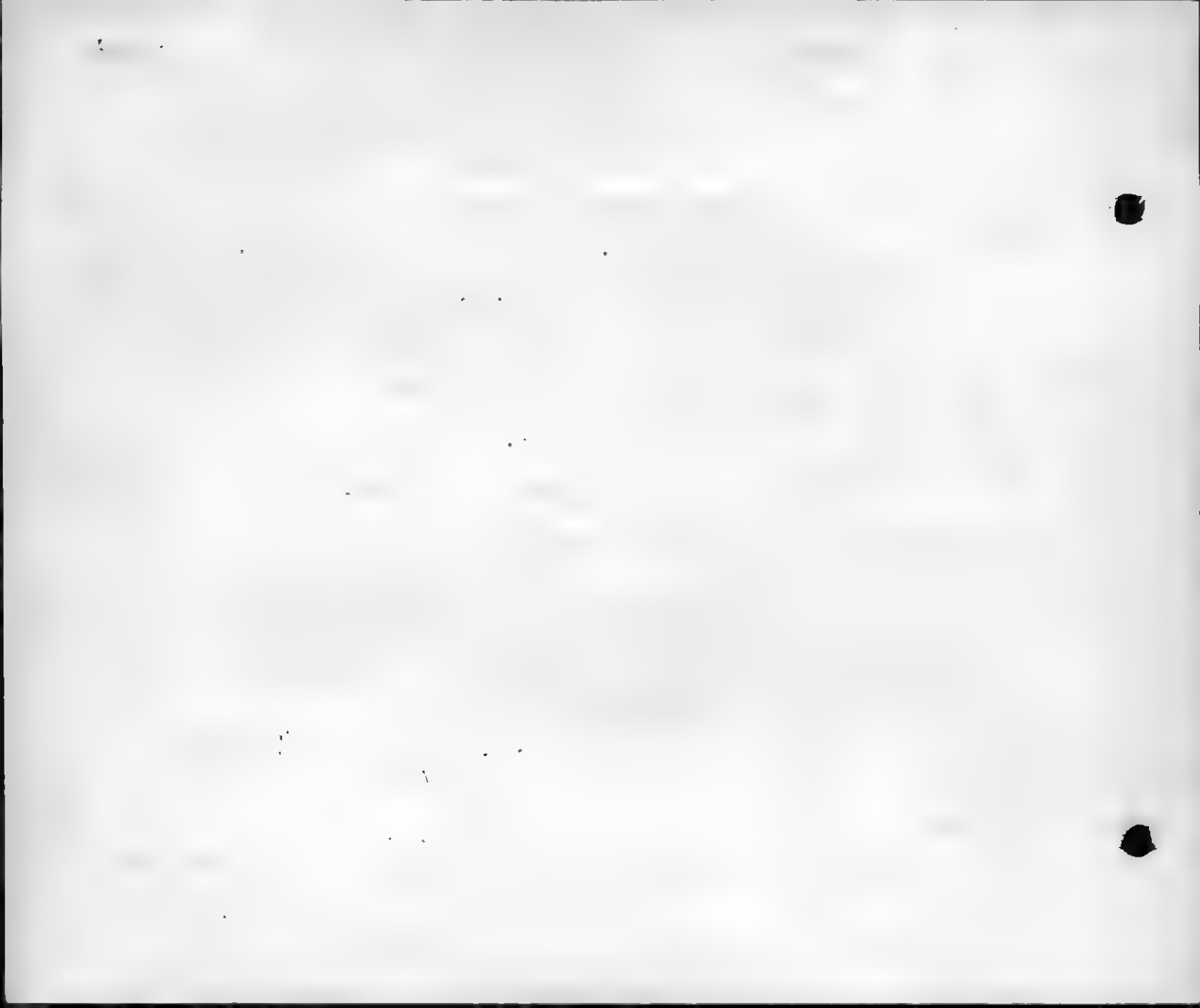
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11063 ^{BIV}

11043

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution - Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | SS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home | | | | d. STREET ADDRESS 526 Castle Drive #12 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | First S. | | Last CONNER | | 4. DATE OF DEATH Month Oct. Day 29 Year 19 60 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 1, 1876 | |
| 9. AGE (In years last birthday) 84 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Conner | | | | 14. MOTHER'S MAIDEN NAME Mary Kuckle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Grace Tavenner-526 Castle Drive #12 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 2, 1960 to Oct. 29, 1960 , that (I) (we) last saw the deceased alive on Oct. 29, 1960 , and that death occurred at 1:15 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Laurence C. Post | | | | 22b. DATE 10/31/60 | | 22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST | |
| 22d. ADDRESS 6805 York Rd. Baltimore 12 | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/1/60 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 23d. LOCATION (City, town, or county) (State) Pikesville, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker | | | | 24b. ADDRESS 1717 N. ... | | 25a. REC'D BY REGISTRAR DATE NOV 2 '60 | |
| 25b. REGISTRAR'S SIGNATURE William S. ... | | | | | | | |



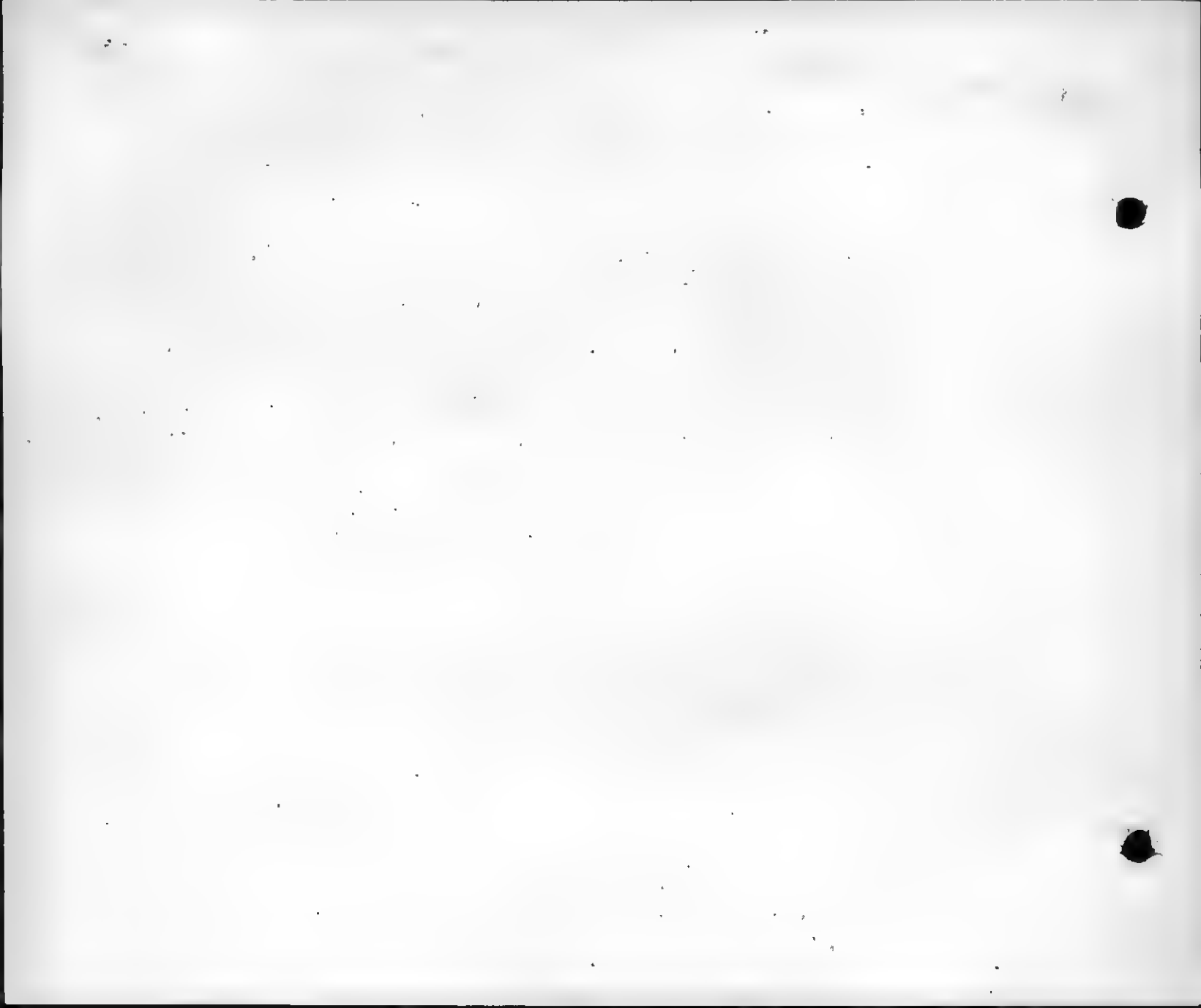
CERTIFICATE OF DEATH

Reg. Dist. No. 11044

11064

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Pearl</u> <u>Patrina</u> <u>Corkran</u> | | 4. DATE OF DEATH Month Day Year <u>Oct. 1</u> , 19 <u>60</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 16, 1909</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. Wilson</u> | 11. BIRTHPLACE (State or foreign country) <u>Yakeshborough, Pa.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Emuzio Panebiarco</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Caroline Riso</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>None</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>210-38-0170</u> | | INFORMANT <u>Mr. Milton W. Corkran, #3 Reservoir Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid with liver metastases</u> 153.3 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>29 yrs</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>14 Oct</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>14 Oct</u> , 19 <u>60</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Gaul Royse</u> M.D. | | ADDRESS (Street, city or town, state) <u>1403 Foley Lane</u> DATE SIGNED <u>15-02-60</u> | |
| PHYSICIAN'S NAME (Type) <u>Paul H Royse MD</u> | | <u>Pikesville 8 Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>Oct. 17, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u> Druid Ridge Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> ADDRESS <u>Pikesville 8, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE OCT 18 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, the funeral director, and the funeral director. After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



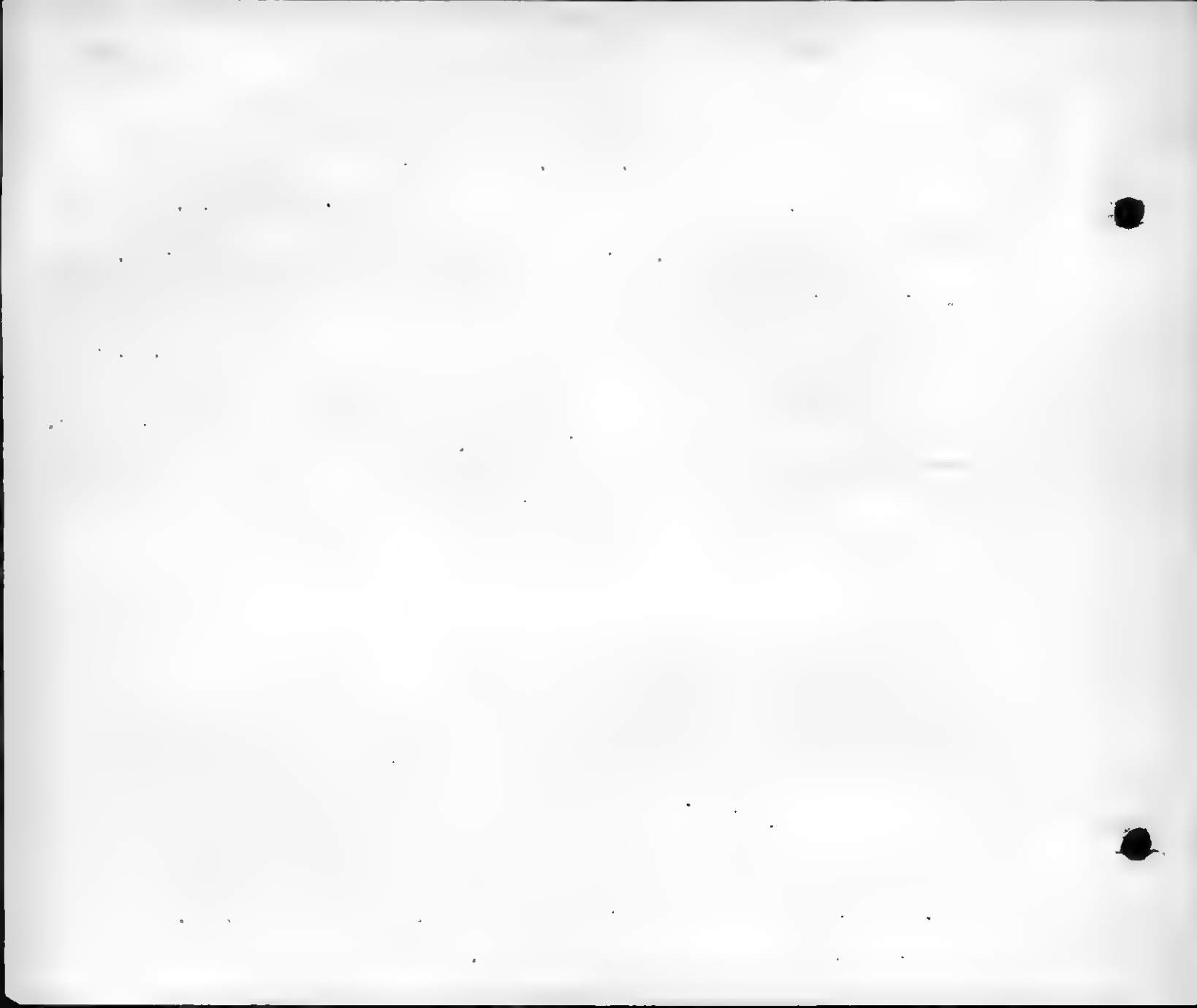
CERTIFICATE OF DEATH

Reg. Dist. No. 11045

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN TB <u>4 mo. 15 da</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>J.</u> Last <u>Cory</u> | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>21st.</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 13, 1879</u> |
| 9. AGE (In years lost birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Wales</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>George Rees</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Ann Davis</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>174-01-3860D</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422-1</u> <u>G. S. C. V. D. & terminal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause lost. (b) <u>Hemipia</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 15, 1960</u> to <u>10/21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>60</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John G. Healey</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 1305 FRANCIS AVE. ASHLEY, N.C. 27, N.C.</u> | |
| PHYSICIAN'S NAME (Type) <u> </u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10/24/1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemetery</u> | 22d. LOCATION (City, town or county) (State) <u>Millersville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> | | 24a. REC'D BY REGISTRAR <u> </u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

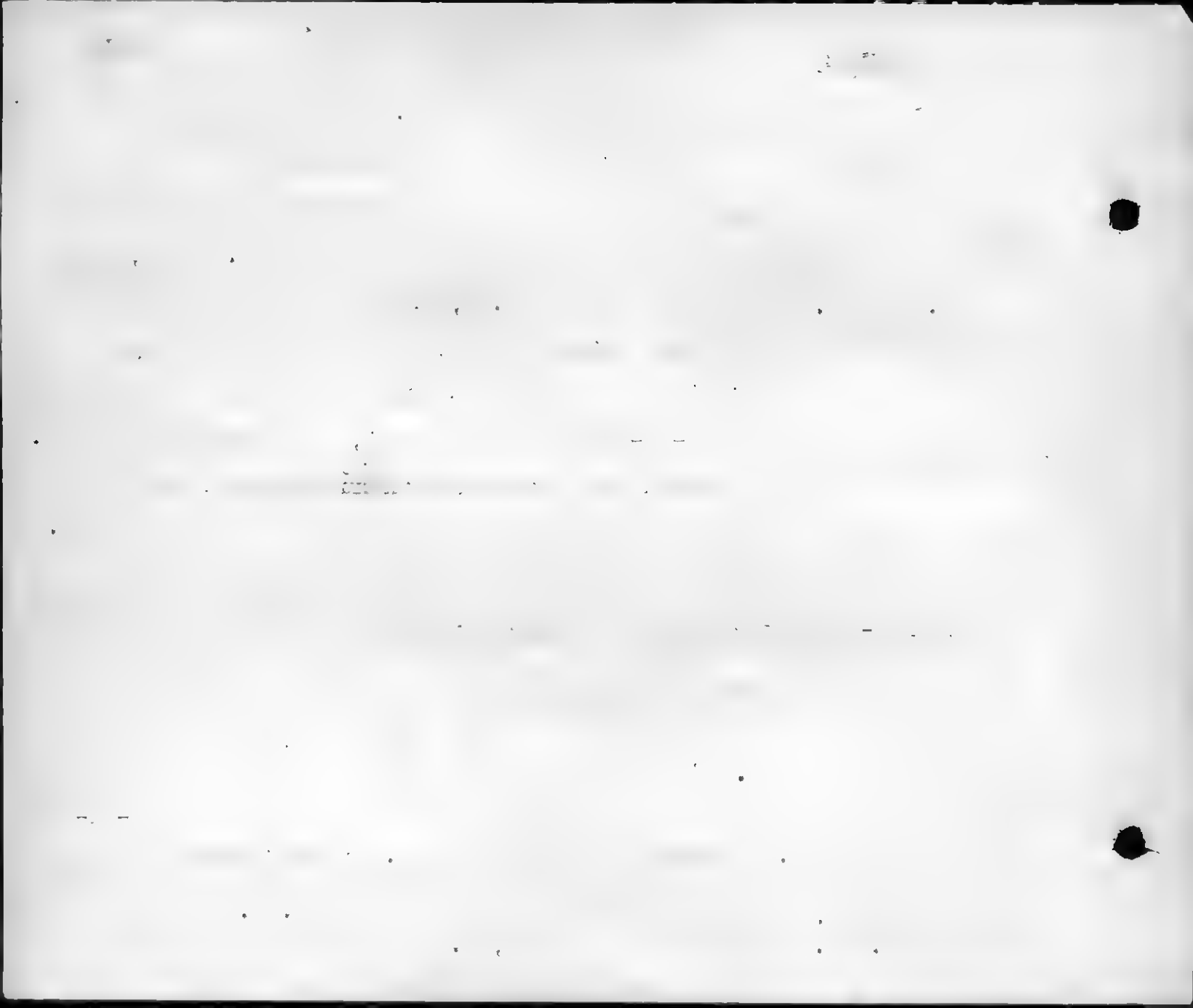


may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11066
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11046

| | | | |
|---|----------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 15 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 Nunnery Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MASSIMO COZZI | | 4. DATE OF DEATH Month Day Year Oct. 20, 1960 | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 25, 1892 |
| 9. AGE (in years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor | | 10b. KIND OF BUSINESS OR INDUSTRY Altone Tailors | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Cozzi | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I | | 16. SOCIAL SECURITY NO. 212-07-5739 | |
| 17. INFORMANT Address Mrs Dora Cozzi, 25 Nunnery Lane #28 Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma right gingiva & jaw 1960 DUE TO (b) left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5 yrs. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic cardio vascular disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1955 to present , 19 60 , that (I) (we) lost the deceased alive on Oct. 18 1960 , and that death occurred at 10 A M, from the causes and on the date stated above | | | |
| 22a. SIGNATURE Arthur G. Siwinski M.D. | | 22b. DATE SIGNED 10-21-60 | |
| 22c. PHYSICIAN'S NAME (Type) Arthur G. Siwinski | | 22d. ADDRESS 15 E. Biddle Street | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 24/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave #29, Md. | | 25a. REC'D BY REGISTRAR Oct 25 60 DATE | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

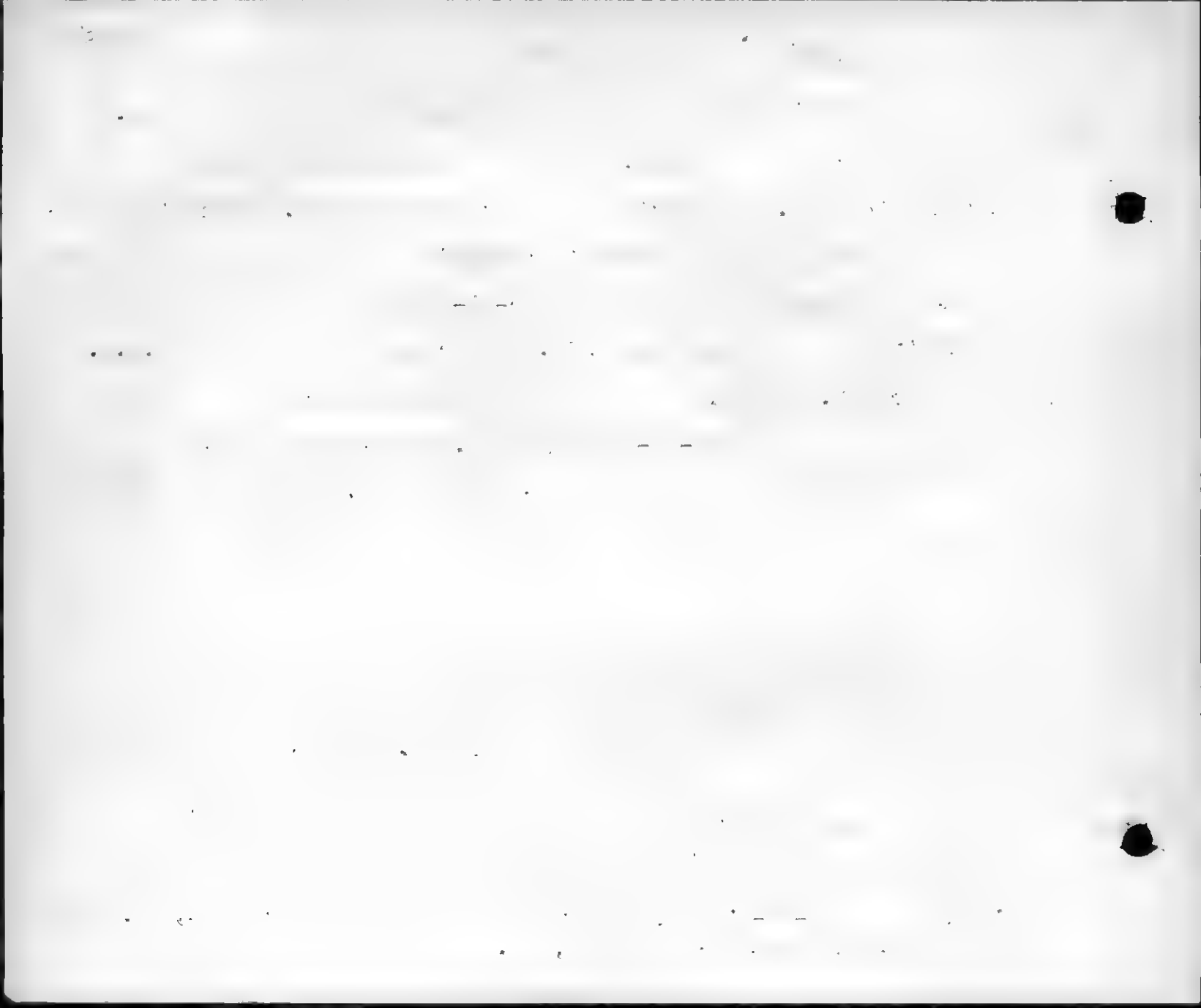
11067

CERTIFICATE OF DEATH

11047

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greenspring Ave. Lutherville | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Eva Middle Jeanette Last Cronhardt | | 4. DATE OF DEATH Month 10 Day 26 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-30-1896 |
| 9. AGE (In years last birthday) yrs. 64 | | 10. IF UNDER 1 YEAR Months 10 Days 26 Hours 1960 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner | | 10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George S. Forwood | | 14. MOTHER'S MAIDEN NAME Helen Waterson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 214-22-6409 | |
| 17. INFORMANT Myron A. Cronhardt | | Address Above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Colon with Metastasis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 1953 to Oct 26th, 1960 , that I last saw the deceased alive on Oct 25th, 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1331 Reisterstown Rd. Pikesville, Md. DATE SIGNED 10/27/60 ACTUAL SIGNATURE James A. Miller M.D. PHYSICIAN'S NAME (Type) James A. Miller M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-29-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 22d. LOCATION (City, town, or county) (State) Pikesville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 28 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |



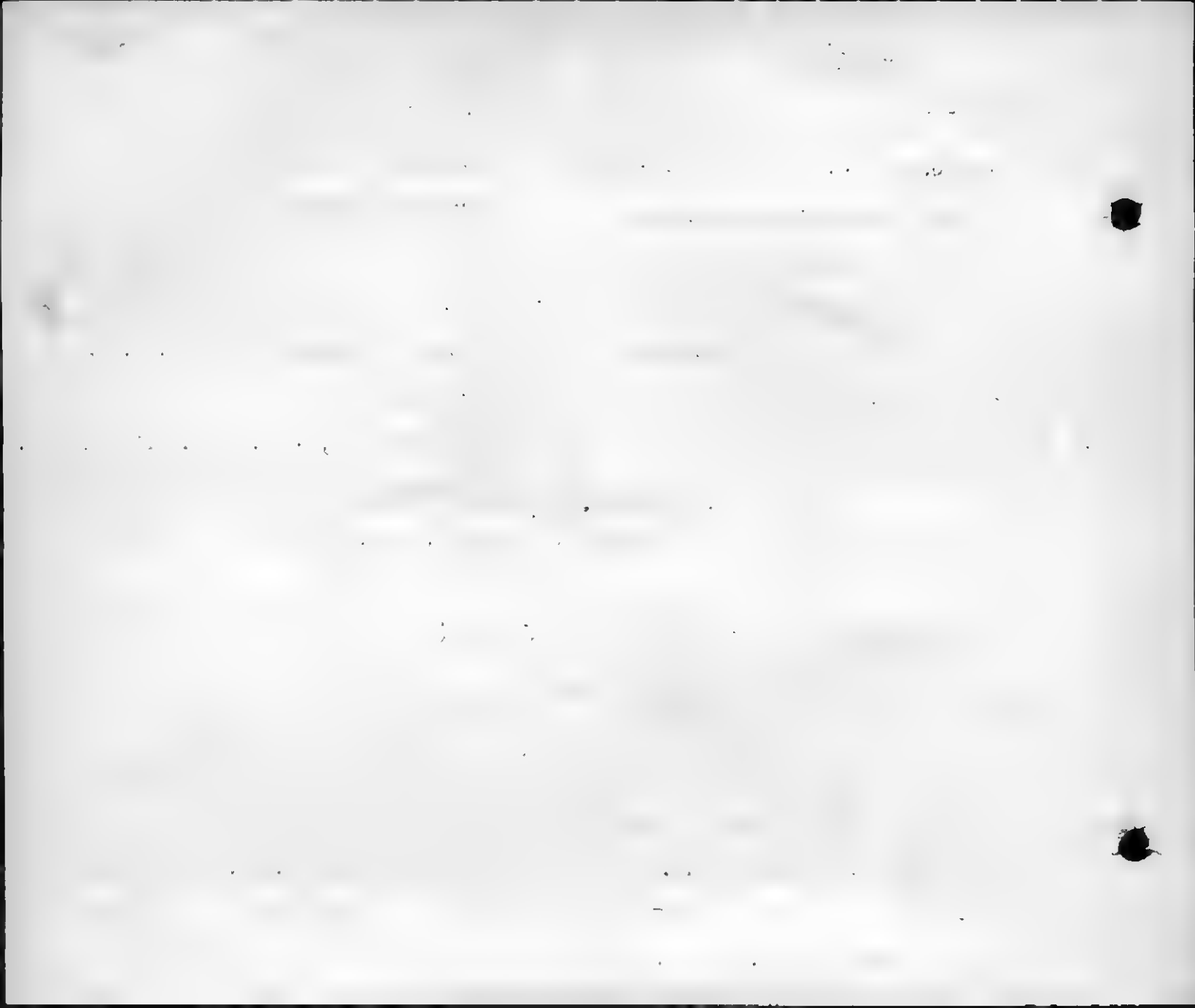
may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11068

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11048

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard Md. c. LENGTH OF STAY IN 1b 45 Minutes | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY (31) | | | |
| 3. NAME OF DECEASED (Type or print) JAMES First Middle Last --- CZYZIA | | | | 4. DATE OF DEATH Month Day Year October 13 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH September 22, 1907 | |
| 9. AGE (In years last birthday) 53 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS. Months Days Hours Min | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor | | | | 10b. KIND OF BUSINESS OR INDUSTRY Tailoring | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Samuel Czyzia | | | | 14. MOTHER'S MAIDEN NAME Josephine Majka | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO 216-09-8933 | | 17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE BILATERAL ADRENAL HEMORRHAGE (WATERHOUSE-FRIDERICHSEN SYNDROME) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO LOBAR PNEUMONIA, BILATERAL, PNEUMOCOCCAL (c) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY Plus 4 DAYS Plus | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE- DURATION UNKNOWN | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6:00 PM 10/13/60 to 6:45 PM 10/18/60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/13/60 19 and that death occurred at 6:45 P. M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Frederick S. Donaldson | | | | 22b. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22c. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-19-60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Dippel Brothers, Inc. 1800 E. Lombard St. (24) | | | | 25a. REC'D BY REGISTRAR OCT 17 '60 | | 25b. REGISTRAR'S SIGNATURE Robert S. Thomas | |



11069

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11049

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|---|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore County | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | | | c. LENGTH OF STAY IN 1b Fruitland | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | d. STREET ADDRESS Poplar St 22X-2 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ROLAND Middle DASHIELL Last DASHIELL | | | | 4. DATE OF DEATH Month 10 Day 11 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-1-1918 | 9. AGE (In years last birthday) 42 yrs | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Louis Dashiell | | | | 14. MOTHER'S MAIDEN NAME Georgia Furness | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 154-01-3363 | | 17. INFORMANT Address Hosp. Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 002X DUE TO Far Advanced Pulmonary Tuberculosis | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO 5 years | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Diabetes Mellitus | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-7 19 60 to 10-11 19 60 , that (I) (we) last saw the deceased alive on 10-11 19 60 and that death occurred at 7:20 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Wm. Newcomer | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent | | | | 22d. ADDRESS Mt. Wilson St. Hospital, Mt. Wilson, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial | | 23b. DATE THEREOF 10-16-60 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary | | 23d. LOCATION (City, town, or county) (State) Fruitland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md | | | | 25a. REC'D BY REGISTRAR DATE OCT 20 1960 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Jones | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



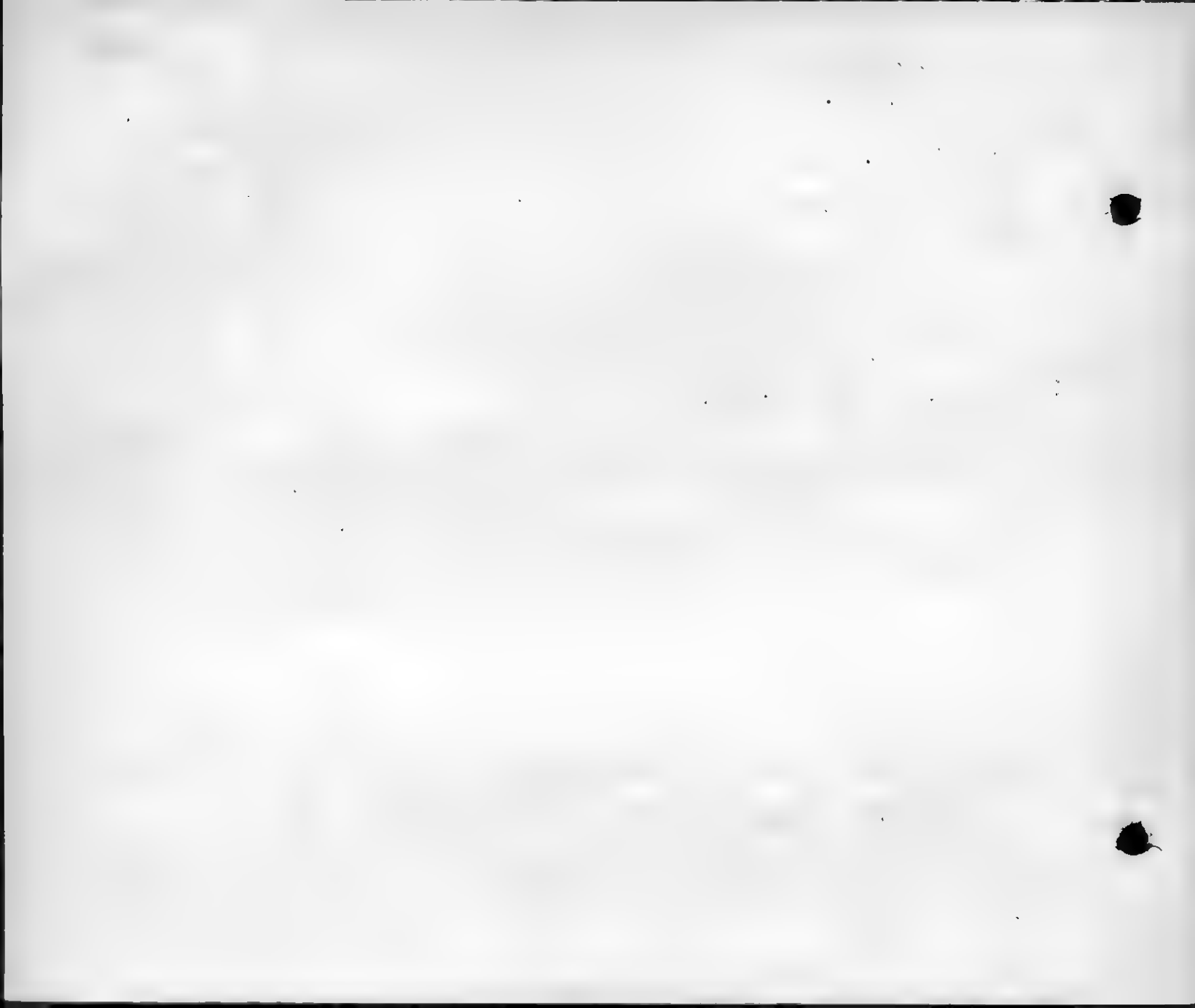
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11070

11050

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 MAPLE AVE | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE 52 d. STREET ADDRESS 108 MAPLE AVE 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last A. ELLA DAVIS | | 4. DATE OF DEATH Month Day Year OCT. 9 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/2/71 |
| 9. AGE (In years last birthday) 88 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC | 11. BIRTHPLACE (State or foreign country) MD. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WM. MERSON | |
| 14. MOTHER'S MAIDEN NAME SCOTT | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO | | 17. INFORMANT Address EMANUEL DAVIS (SON) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basil Cell Carcinoma of Jaw. 191.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho Pneumonia DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 2 years 210 days. | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Jan 1956 to Oct 9 1960 that (I) (we) last saw the deceased alive on Oct 8 1960 and that death occurred at 539A from the causes and on the date stated above | |
| 22a. SIGNATURE Wm. Lee Fort | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wetherbee Fort | | 22d. ADDRESS 6 outton ave. Catonsville 28 md | |
| 23a. BURIAL, CREMAT ON, REMOVAL (Specify) | 23b. DATE THEREOF 10/11/60 | 23c. NAME OF CEMETERY OR CREMATORY ST. JANE | 23d. LOCATION (City, town, or county) (State) HOWARD CO. MD. |
| 24. FUNERAL DIRECTOR'S SIGNATURE John Smith + Son 28 | | 25a. REC'D BY REGISTRAR DATE OCT 13 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Krand | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11051

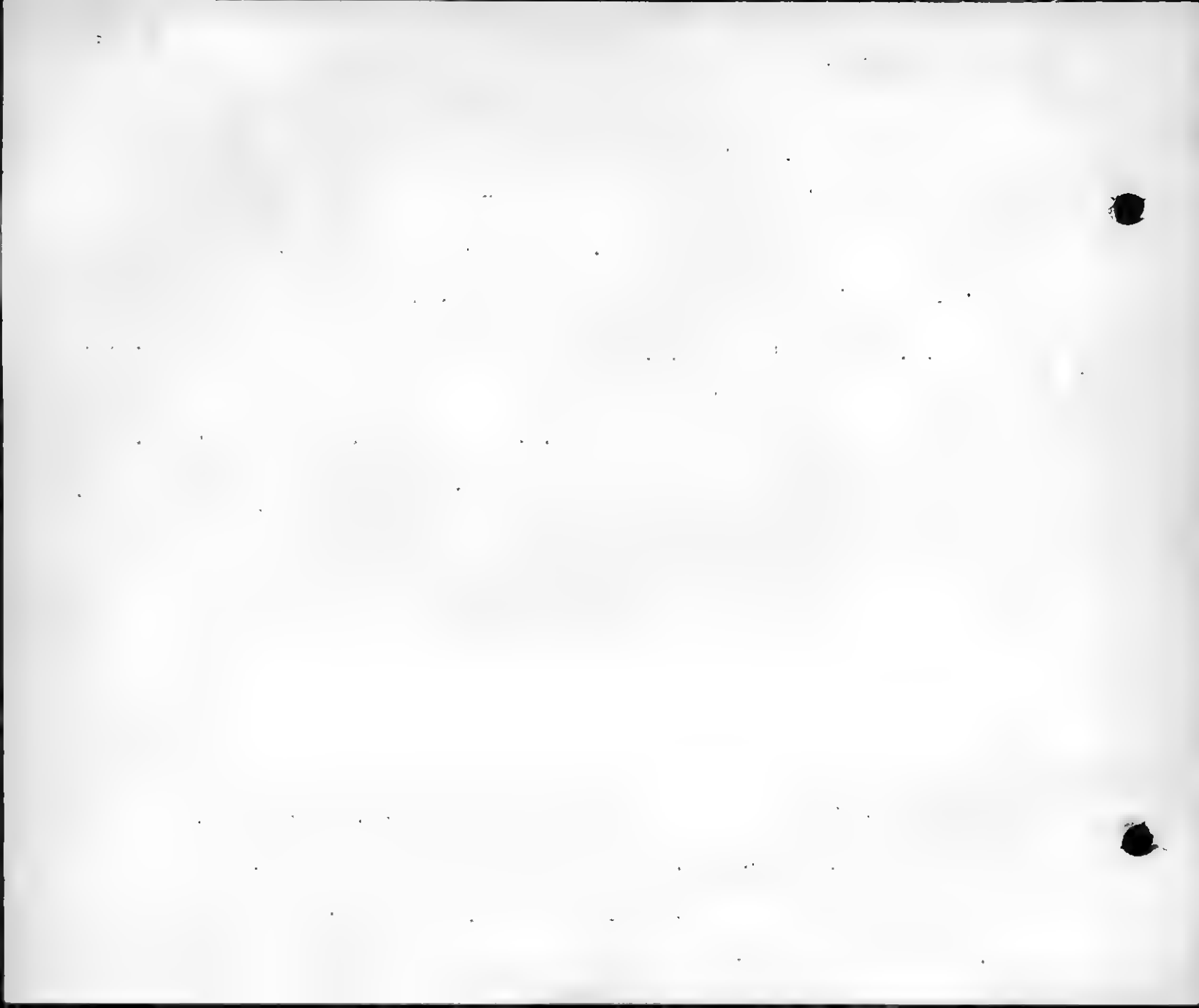
Reg. Dist. No.

11071

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The House in the Pines 16 Rusting Avenue | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore 29 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29 d. STREET ADDRESS 810 North Chapel Gate Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Howard Middle C. Last Davis | | 4. DATE OF DEATH Month October Day 5 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 11, 1895 |
| 9. AGE (In years last birthday) 65 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army (ret'd) | 11. BIRTHPLACE (State or foreign country) Missouri |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME unknown | |
| 14. MOTHER'S MAIDEN NAME unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW 11 | |
| 16. SOCIAL SECURITY NO. 220-07-0521 | | 17. INFORMANT Wm. E. Schoeberlein, 924 Masefield Rd. ZONE 7 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung (Bronchiogenic Carc.) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6/3, 1960 , to 10/5, 1960 , that I last saw the deceased alive on 10/5, 1960 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Max J. Miller | | ADDRESS (Street, city or town, state) 1047 Ingleside Ave, Baltimore | |
| PHYSICIAN'S NAME (Type) Max J. Miller, M.D. | | DATE SIGNED 280/7/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 10-10-60 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) (State) Baltimore |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR OCT 10 '60 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

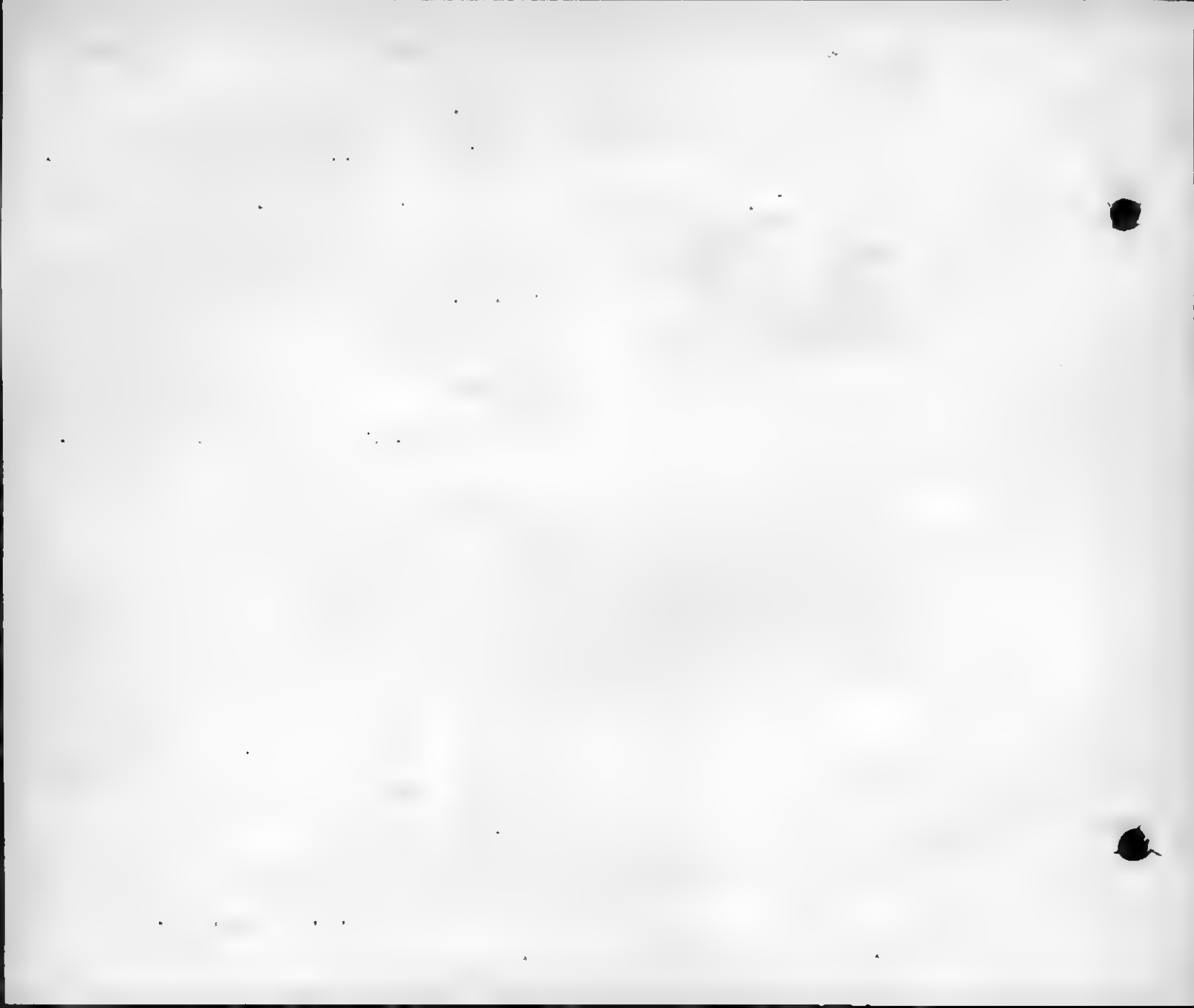
VR A15 (4)
15M 9/59

11072

11052

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 4 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1302 Iverness Ave Baltimore, Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1821 Loch Shiel Rd. | | d. STREET ADDRESS 1302 Iverness Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Katharina Doll | | 4. DATE OF DEATH 10/25/60 Month 10 Day 25 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 15, 1897 |
| 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) none | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Henriette Harman, 1821 Loch Shiel Rd. #4 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Sarcinosis DUE TO (b) possib originating from R.O.R. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 2 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day Year 19 Hour o. m. p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March, 1960 to 10.25. 1960 , that (I) (we) last saw the deceased alive on 10.24. 1960 , and that death occurred at 7:30 M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James H. Hubbard | | 22b. DATE SIGNED 10.26.60 | |
| 22c. PHYSICIAN'S NAME (Type) James H. Hubbard | | 22d. ADDRESS 2151 Wilkens Ave, Baltimore Md | |
| 23a. BURIAL, CREMATION, REMOVAL. (Specify) Burial | | 23b. DATE THEREOF 10/28/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Cross | | 23d. LOCATION (City, town, or county) (State) A.A. County Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | 25a. REC'D BY REGISTRAR DATE OCT 28 '60 | |
| ADDRESS 4107 Wilkens Ave. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11073 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11053

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|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if last before admission) a. STATE MD | | b. COUNTY Balto | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Pikesville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Foxleigh Nursing Home | | d. STREET ADDRESS 3400 Winterset Court | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ESTHER HINDA DOPKIN | | 4. DATE OF DEATH Oct 26, 1960 | | 5. 19 Year | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 8. DATE OF BIRTH August 4, 1893 | |
| 13. FATHER'S NAME Isadore Goldman | | 14. MOTHER'S MAIDEN NAME Sarah M. ? | | 9. AGE (In years last birthday) 67 yrs. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO. Mr. Wilford Dopkin | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 17. INFORMANT Same | | Address | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Heart disease DUE TO (b) 722.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | |
| Fracture left femur--- Malnutrition due to esophageal diverticulum | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. No | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home aug 1959 | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 3 AM p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | |
| | | 20f. (City or town) Baltimore, Md | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE D.D. Caples | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 10/26/60 | |
| EXAMINER'S NAME (Type) D.D. Caples | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/27/60 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew | |
| 23. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. 6010 Reisterstown Rd. | | ADDRESS | | 24a. REC'D BY REGISTRAR OCT 31 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION



11074

CERTIFICATE OF DEATH

11054
Reg. Dist. No.

| | | | |
|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1229 SIXTY-THIRD ST. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BEATRICE FLEANNOR DWYER | | 4. DATE OF DEATH OCT. 21 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 13 1914 |
| 9. AGE (In years last birthday) 46 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS | | 10b. KIND OF BUSINESS OR INDUSTRY G.A. RESTAURANT | |
| 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ROBERT L. CROUT | | 14. MOTHER'S MAIDEN NAME LAURA ROBINSON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 218-05-2994 | |
| 17. INFORMANT JOSEPH J. DWYER | | Address 1229 63rd ST. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - Bronchogenic Carcinoma 162-1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mo. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from OCT. 21, 1960 to OCT. 21, 1960 that I last saw the deceased alive on OCT. 21, 1960 , and that death occurred at 8:55 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 4810 Bowleys Lake DATE SIGNED 10/22/60 | | | |
| ACTUAL SIGNATURE Stephen Toms, M.D. | | PHYSICIAN'S NAME (Type) STEPHEN TOMS, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF OCT. 25, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | 22d. LOCATION (City, town, or county) (State) BALTO. CO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Geo. W. Hoffmann | | ADDRESS 3218 HUDSON ST. | |
| 24a. REC'D BY REGISTRAR OCT 24 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



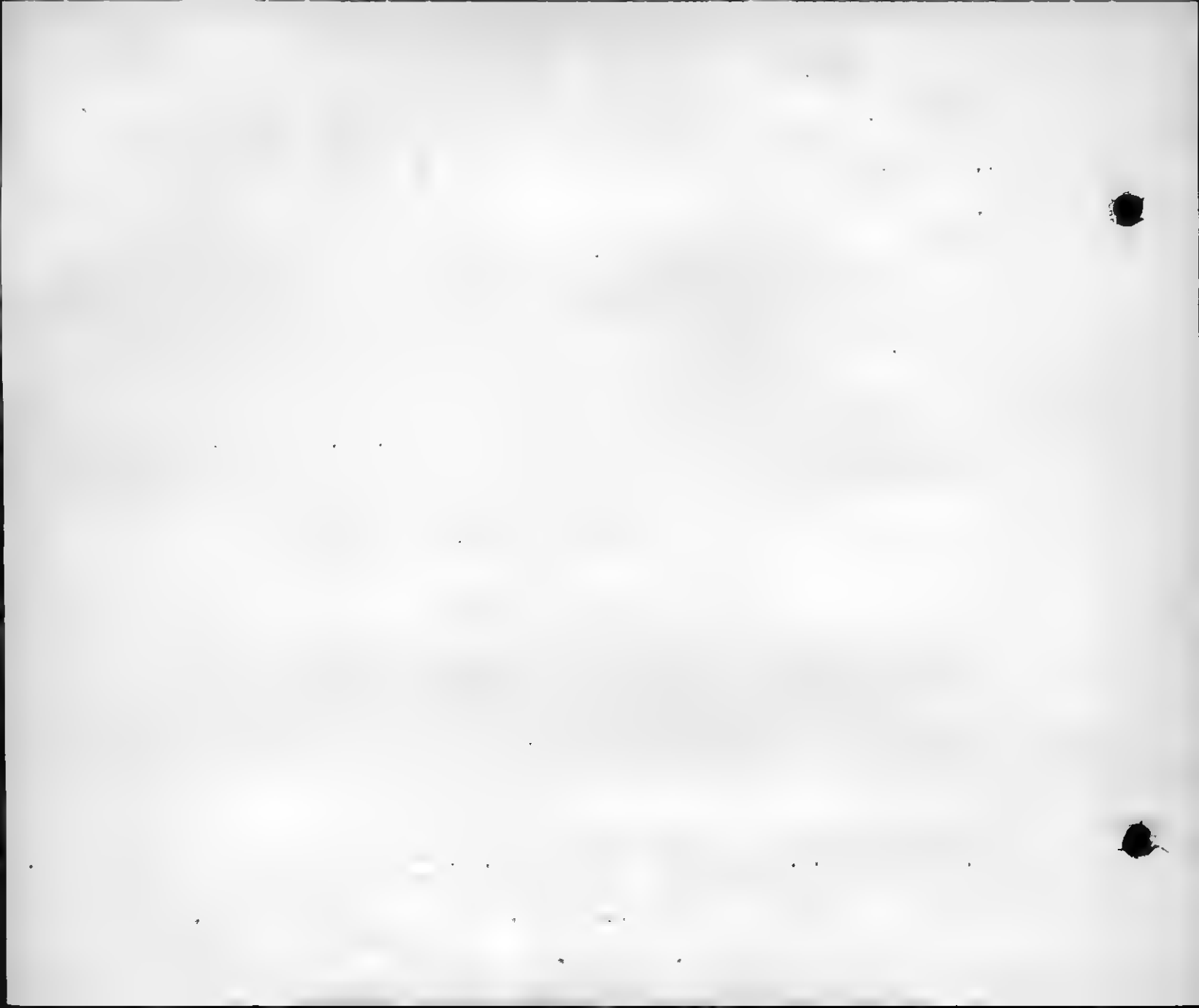
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11075

11055

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED First Middle Last EARL EDWARD EIDMAN | | | | 4. DATE OF DEATH Month Day Year 10 26 1960 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-10-05 | |
| 9. AGE (In years last birthday) 55 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME JOHN E. EIDMAN | | | | 14. MOTHER'S MAIDEN NAME EMMA SCHWEIM | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 217-07-6987 | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE DUE TO (b) ESOPHAGEAL VARICES DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS, DIABETES | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-6 , 1960 to 10-26 , 1960 ; that (I) (we) last saw the deceased alive on 10-26 , 1960 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Wm. Newcomer | | | | 22b. DATE SIGNED 10-26-60 | | 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent | |
| 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md. | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22f. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/31/60 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. | | 23d. LOCATION (City, town, or county) (State) Glen Burnie, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. Cully Funeral Homes | | | | 25a. REC'D BY REGISTRAR DATE OCT 28 1960 | | 25b. REGISTRAR'S SIGNATURE Carlton S. Kneale | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

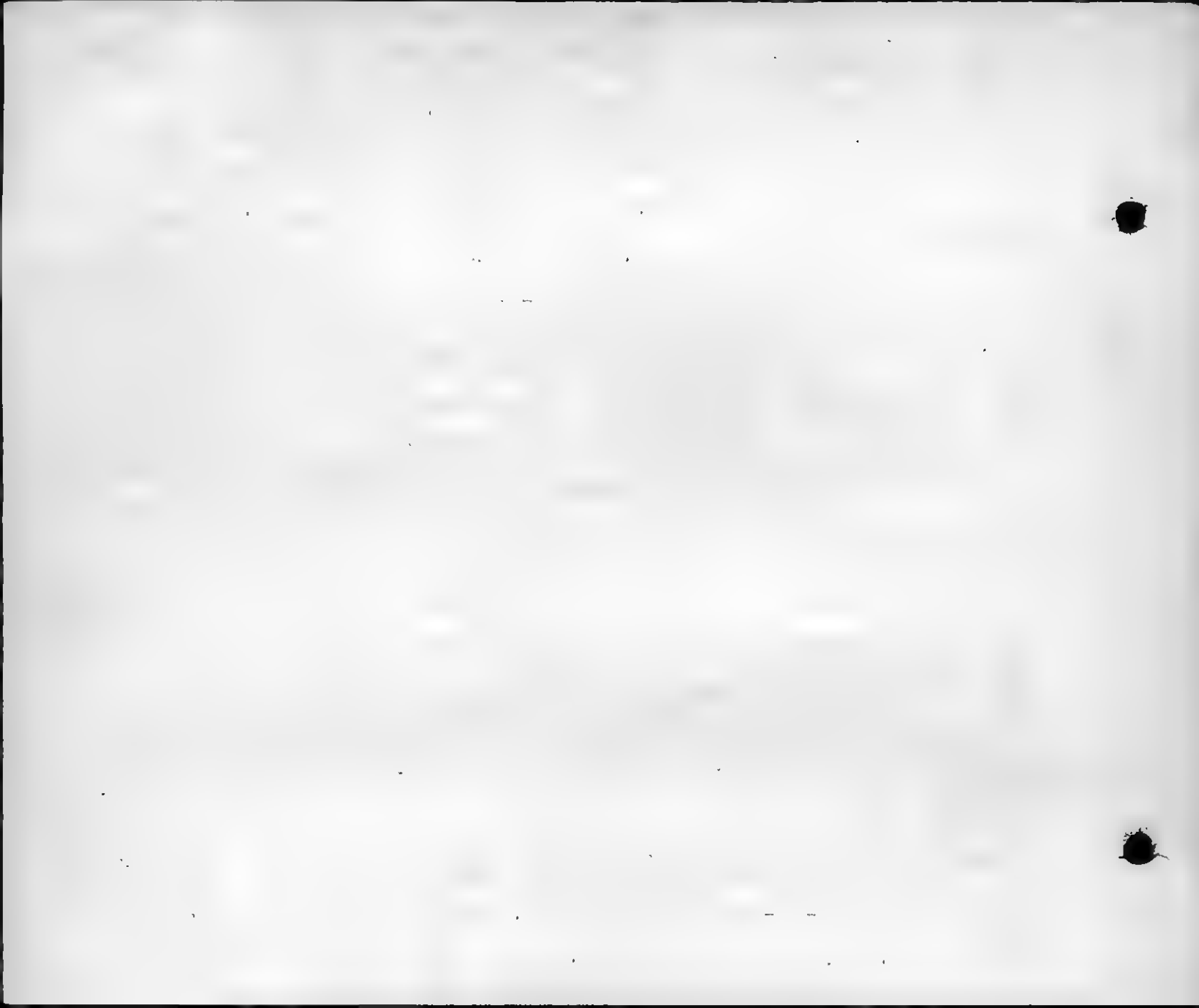
CERTIFICATE OF DEATH

Reg. Dist. No. **11056**

11078

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1105 Register Ave. | | d. STREET ADDRESS 1105 Register Ave. | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle H. Last Eliff | | 4. DATE OF DEATH Month 10 Day 10 Year 19 60 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-9-1886 |
| 9 AGE (In years last birthday) 74 yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Eliff | | 14. MOTHER'S MAIDEN NAME Cluy Norris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. 212321468 | |
| 17. INFORMANT Frances Eliff | | Address same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Lung (Left) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 15 1959 to Oct 10 1960 , that I last saw the deceased alive on Oct 10 1960 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Laurence C. Post | | ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore Md | |
| PHYSICIAN'S NAME (Type) LAURENCE C. POST | | DATE SIGNED 10/11/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 10-13-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | 24a. REC'D BY REGISTRAR DATE OCT 13 '60 | |
| ADDRESS 5305 Hargford Rd. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11077

11057

| | | | | | | | |
|---|-------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | | | c. LENGTH OF STAY IN 1b 57 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 SEMINOLE AVE | | | | d. STREET ADDRESS 1506 SEMINOLE AVE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last BERTHA MAY ENNIS | | | | 4. DATE OF DEATH Month Day Year October 30 1960 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 18, 1885 | | 9. AGE (In years lost birthday) 75 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Hastings | | | | 14. MOTHER'S MAIDEN NAME Nancy E. Grauehor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address Mrs. Doris McCurdy 506 SEMINOLE AVE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hr. |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure | | | | | | | years. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1956 to 10/30 , 19 60 that (I) (we) last saw the deceased alive on 10/30 , 19 60 , and that death occurred over P.M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE E. P. Williamson M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 10/30/60 | |
| 22c. PHYSICIAN'S NAME (Type) E. P. WILLIAMSON II | | | | 22d. ADDRESS 5550 BALTO. NAT'L PIKE BALTIMORE 28 Md. | | | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF Nov. 2, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK | | 23d. LOCATION (City, town, or county) (State) SALISBURY, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Holloway & Co SALISBURY, Maryland | | | | 25a. REC'D BY REGISTRAR DATE NOV 2 '60 | | 25b. REGISTRAR'S SIGNATURE William S. Thomas | |

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

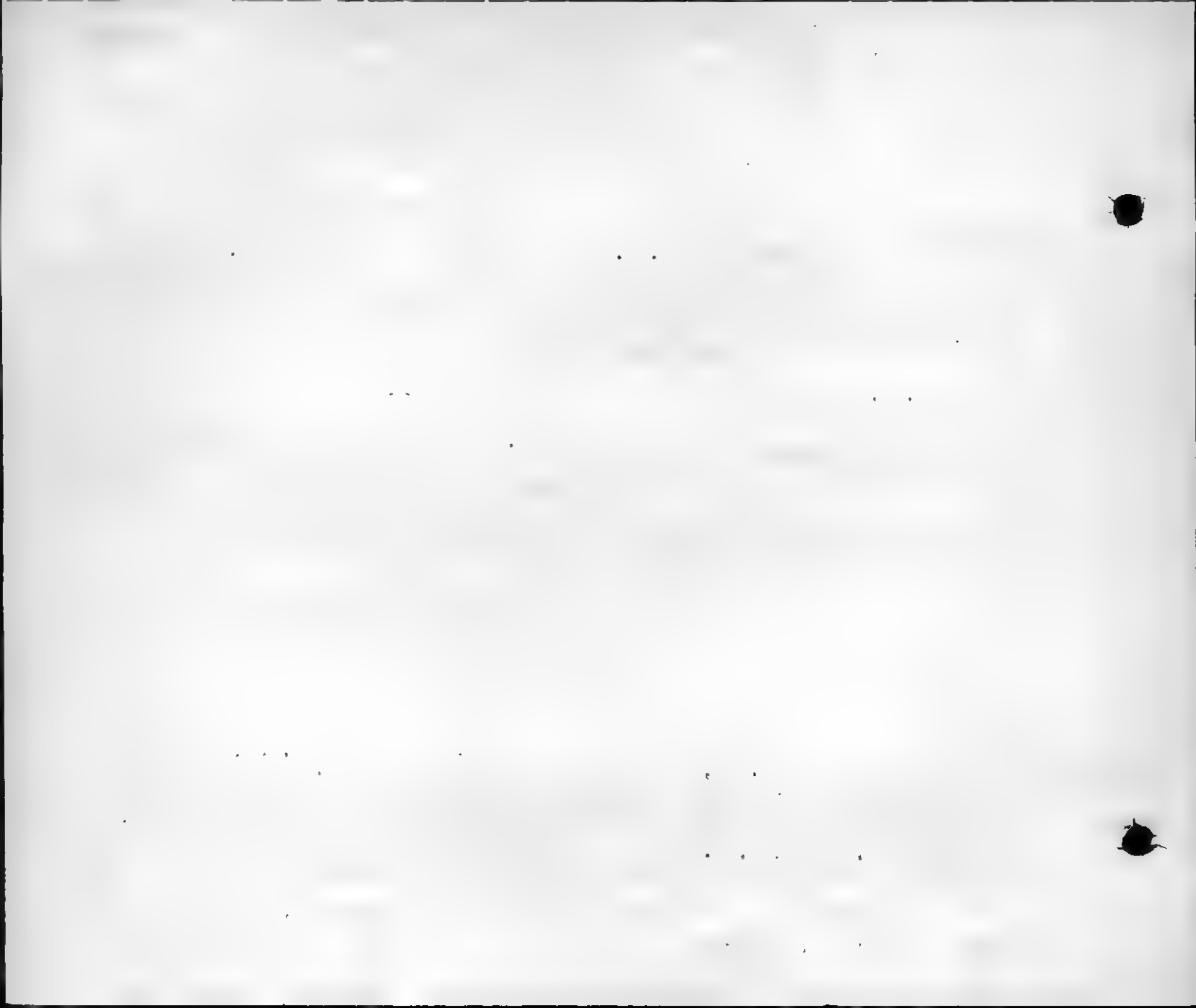
VR A15 (4)
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11078

11058

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN TB | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 443 Whitfield Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN' Middle E. T. Last EWELL | | | | 4. DATE OF DEATH Month Oct. Day 30 Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 23, 1890 | | 9. AGE (In years last birthday) yrs 70 | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore City | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Oscar B. B. Ewell | | | | 14. MOTHER'S MAIDEN NAME Mary ----- | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO None | | 17. INFORMANT Address Mrs. Minnie Ewell-443 Whitfield Road #28 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma of lung 153.3 DUE TO Carcinoma of sigmoid colon Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8/1/58 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 24, 1955 to Oct. 30, 1960 that (I) (we) last saw the deceased alive on Oct. 29, 1960 and that death occurred at 12:30 A.M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>Harry L. Knipp</i> | | | | M D ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 10/31/60 | |
| 22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M. D. | | | | 22d. ADDRESS 4116 Edmondson Avenue #29 | | | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/2/60 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J. Tucker</i> | | | | 25a. REC'D BY REGISTRAR DATE NOV 2 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i> | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

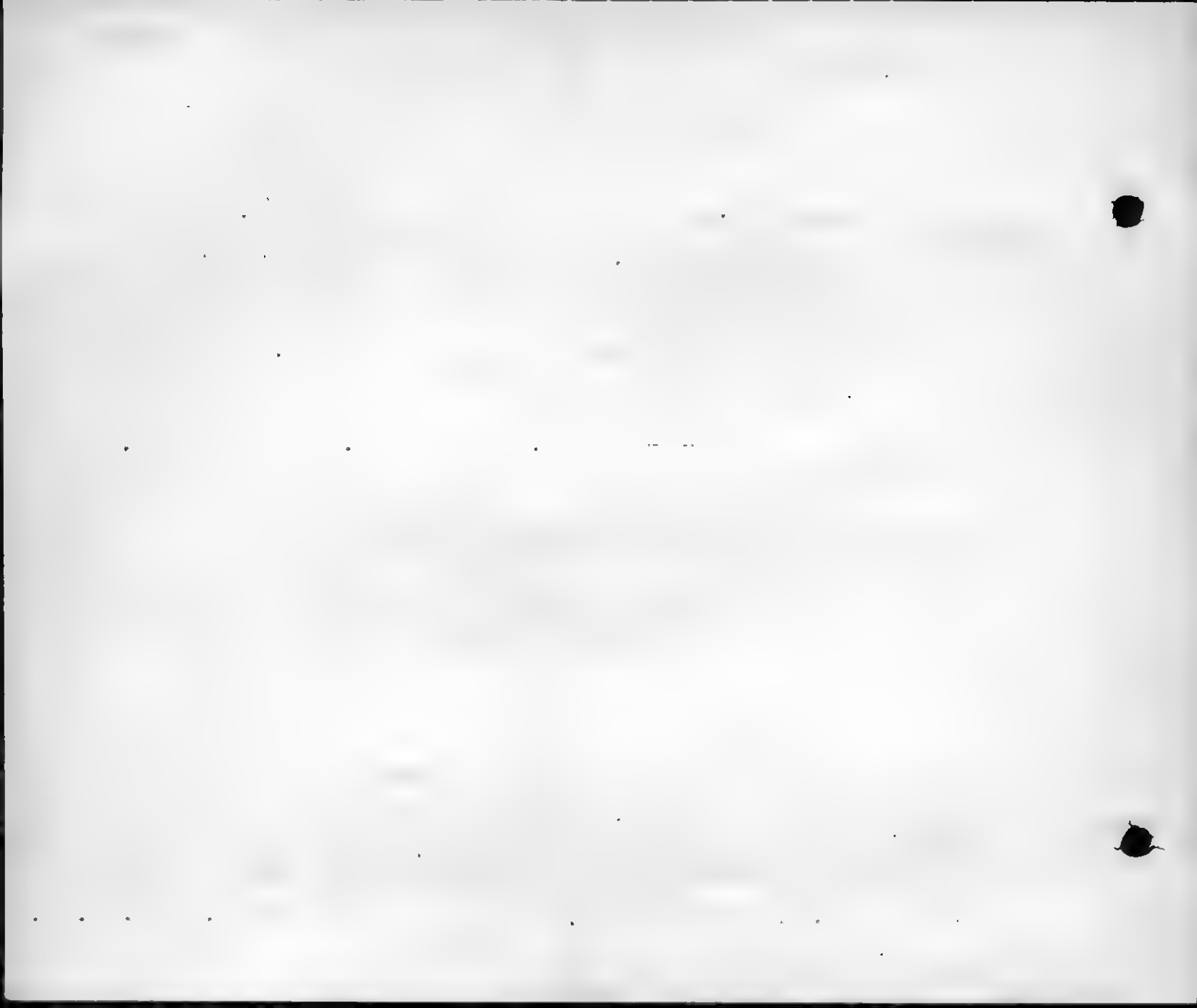
1

11079

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11059

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1110 Chesaco Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>F.</u> Last <u>Ey</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5, 1913</u> |
| 9. AGE (In years lost birthday) <u>47</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Martin Aircraft</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Ey</u> | | 14. MOTHER'S MAIDEN NAME <u>Louise Pocock</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service, <u> </u>) | | 16. SOCIAL SECURITY NO. <u>213-05-5852</u> | |
| 17. INFORMANT <u>Mr. Clarence Ey Jr.</u> | | Address <u>1110 Chesaco Ave. 6</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Chronic stenotic heart disease</u> DUE TO <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>653</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from <u>22 June 1958</u> to <u>14 Aug 1958</u> that (2) (we) last saw the deceased alive on <u>15 Oct 1960</u> and that death occurred at <u>110</u> M, from the causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Frederick H. [Signature]</u> | | 22b. DATE SIGNED <u> </u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Frederick H. [Signature]</u> | | 22d. ADDRESS <u>8019 Phila Rd. Balt., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 1, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u> | 23d. LOCATION (City, town, or county) (State) <u>Golden Ring Rd. Bal to. Co. Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Carlton L. Kneass</u> | |
| DATE <u>NOV 2 '60</u> | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11080

11060

| | | | | | |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>2-30</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1000 E. ...</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>MARG. ELIZ. FERGUSON</u> First Middle Last 4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1960</u> | | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-24-1870</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u> IF UNDER 24 HRS. Hours <u>12</u> Min. <u>30</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | 13. FATHER'S NAME <u>John Lavin Kilian</u> 14. MOTHER'S MAIDEN NAME <u>Ann Frances Nash</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO <u>215-01-8800</u> 17. INFORMANT <u>Mary Kilian Price</u> Address <u>2150 ...</u> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> (b) <u>Diabetic</u> (c) <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gold & Chlor.</u> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year <u>2004</u> Hour a.m. <u>2</u> p.m. <u>00</u> 20d. INJURY OCCURRED <u>None</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> 20f. (City or town) <u>None</u> (County) <u>None</u> (State) <u>None</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>D.D. Caples</u> M.D. EXAMINER'S NAME (Type) <u>D.D. CAPLES, M.D.</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>104-60</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10/6/1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Granite Presbyterian Cem.</u> 22d. LOCATION (City, town, or country) <u>Granite</u> (State) <u>Maryland</u> | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u> DATE <u>OCT 4 '60</u> | | |

MEDICAL CERTIFICATION



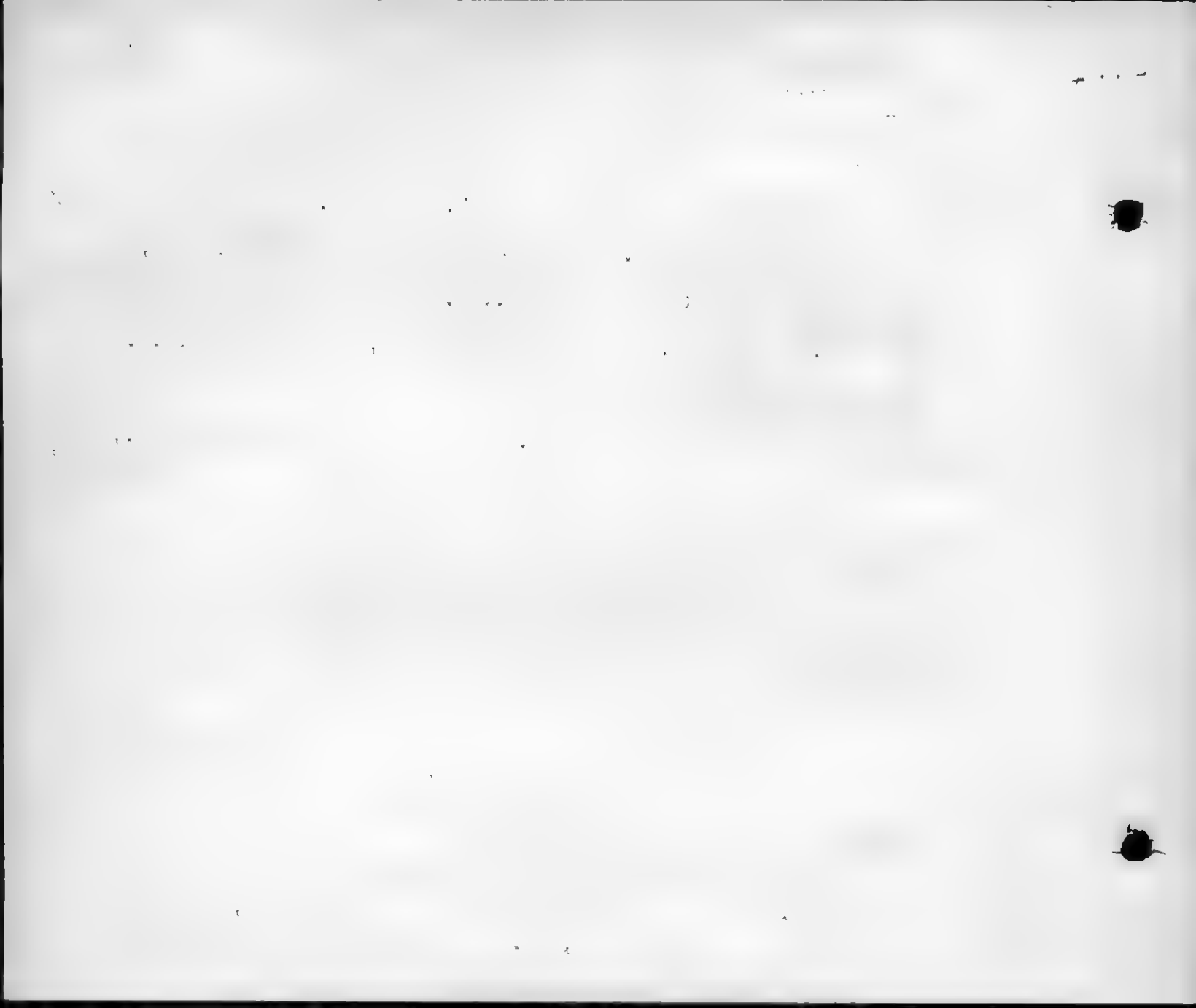
may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11081 Items 8,9 Film G273 10-20-60 et
CERTIFICATE OF DEATH

11061

| | | | | | |
|--|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1 week | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines Nursing Home | | | d. STREET ADDRESS 1110 S. Carey st. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle W. Last FINECEY | | | 4. DATE OF DEATH Month October Day 5 Year 1960 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1874 22nd Feb. 1874 | | 9. AGE (in years last birthday) 86 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector (ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME (Unknown) Finecey | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | |
| 16. SOCIAL SECURITY NO Unknown | | | 17. INFORMANT Mrs. Ethel Schmidt #9 Ferndale Ave., Glen Burnie, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO L. 20:1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Coronary atherosclerosis (c) General arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 171 187.2 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 9-29-1960 to 10-5-1960 that (I) (we) last saw the deceased alive on 10-5-1960 and that death occurred at 8:30 AM from the causes and on the date stated above | | | |
| 22a. SIGNATURE Richard V. Sengler | | 22b. DATE 10-5-1960 | | 22c. PHYSICIAN'S NAME (Type) Richard V. Sengler | |
| 22d. ADDRESS 629 Frederick Ave., Balt. 28, Md. | | 22e. ATTENDING PHYSICIAN M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8th Oct. 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | |
| 23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | | 24. FUNERAL DIRECTOR'S SIGNATURE Richard V. Sengler ADDRESS Glen Burnie, Md. | | | |
| 25a. REC'D BY REGISTRAR DATE OCT 10 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |



VR A15 (4)
ISM 9/59

11082

11062

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b 17 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2102 Lake Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) HENRY First FISCHER Last | | 4. DATE OF DEATH Month Oct. Day 5, Year 19 60 | |
| 5. SEX male | | 6. COLOR OR RACE white | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 9, 1883 | |
| 9. AGE (In years lost birthday) 77 yrs. | | 10. IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min. IF UNDER 24 HRS | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (rtd) | | 12. KIND OF BUSINESS OR INDUSTRY Printing | |
| 13. FATHER'S NAME Frederick Fischer | | 14. MOTHER'S MAIDEN NAME Bertha ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mrs. Elizabeth F. Sheppard - 2102 Lake Ave. | | Address 2102 Lake Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 148X Cancer of Throat DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 18 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 23rd 1960 to Oct. 5th 1960 , that (I) (we) last saw the deceased alive on Sept. 29th 1960 , and that death occurred on Oct. 5th 1960 , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James A. Miller M.D. M.D. | | 22b. DATE SIGNED 10/6/60 | |
| 22c. PHYSICIAN'S NAME (Type) James A. Miller M.D. | | 22d. ADDRESS 1331 Reisterstown Rd. Pikesville, Md. | |
| 23a. BURIAL (CREMATION, REMOVAL, (Specify)) Burial | | 23b. DATE THEREOF 10/8/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | | 23d. LOCATION (City, town, or county) Balto., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Lickner ADDRESS 1400 N. Kent St. - Baltimore, Md. | | 25a. RECEIVED BY REGISTRAR DATE Oct 7 1960 | |
| 25b. REGISTRAR'S SIGNATURE Wm. L. Lickner | | 25c. REGISTRAR'S NAME Wm. L. Lickner | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If not, it may be necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11063

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|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethlehem Steel Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>2418 E. Fayette St. Zone #24</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>James F. Fitzpatrick</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>60</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-19-1902</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William J. Fitzpatrick</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna M. McPeake</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>213-05-7213</u> | | 17. INFORMANT <u>Anna M. Fitzpatrick</u> Address <u>Same.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hyperuricemia - C-v-D cause</u> (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>420</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>M.B. Davis</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-18-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>7401 German Hill Rd., Md.</u> | |
| 23. FUNERAL DIRECTOR <u>Charles S. Zeiler</u> ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u> | | | | 24a. REC'D BY REGISTRAR <u>ACT 18 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

MEDICAL CERTIFICATION

DATE SIGNED
10/14/60.

M

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

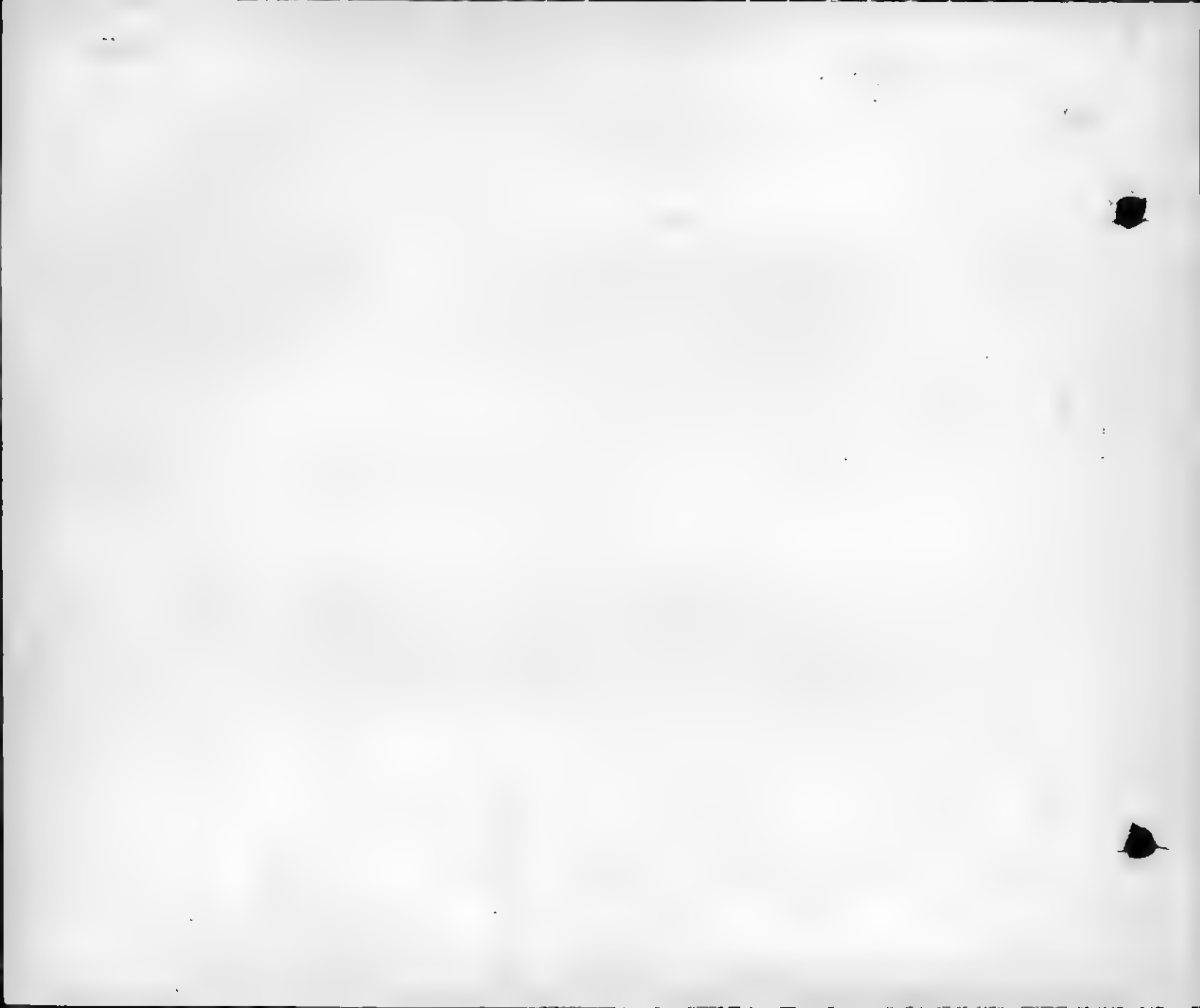
CERTIFICATE OF DEATH

11084

Item 9 Baltimore 15-24-60 at

11064

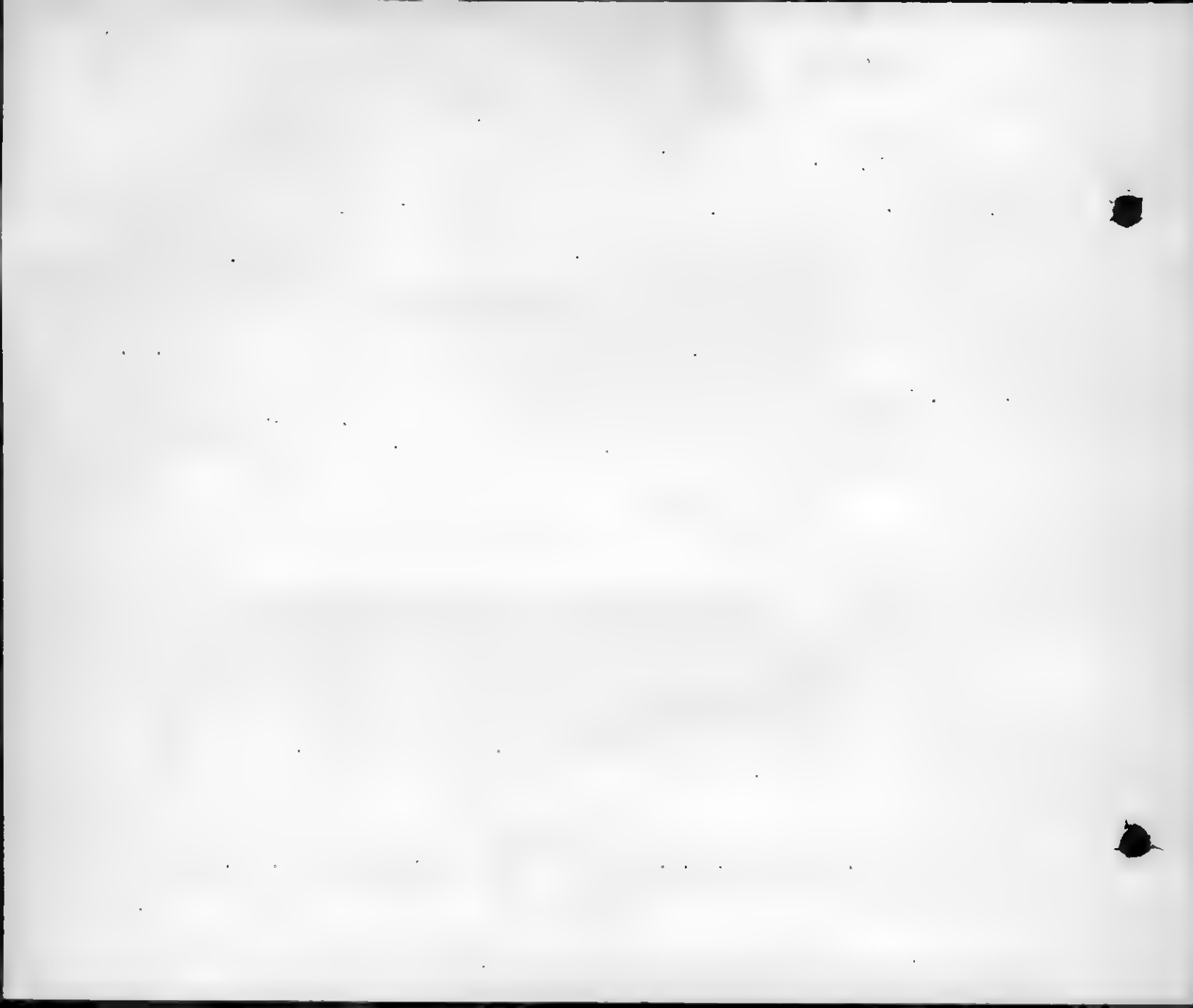
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|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN 1b <u>life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>FINCH</u> Last <u>FLAYHART</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 24 1888</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>pharmacist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>medicine</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Towson</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry W. Flayhart</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Ruby</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>218-07-1282</u> | |
| 17. INFORMANT <u>Mrs Elva W. Flayhart</u> | | Address <u>503 Virginia Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1954</u> to <u>October 60</u> , that (I) (we) last saw the deceased alive on <u>Oct 11</u> 19 <u>60</u> , and that death occurred at <u>4:20</u> M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Lester A. Wall Jr.</u> | | 22b. DATE SIGNED <u>10/13/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>LESTER A. WALL JR</u> | | 22d. ADDRESS <u>1039 St Paul St, Baltimore 2</u> | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>15 Oct. 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Towson, Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u> | | 25. REC'D BY REGISTRAR <u>OCT 18 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u> | | | |



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| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 30 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institut on - Residence before admission) a. STATE Maryland b. COUNTY Baltimore (13) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (13) d. STREET ADDRESS 3301 Ramona Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle MATTHEW Last FRANK | | 4. DATE OF DEATH Month October Day 19 Year 1960 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 14, 1911 | |
| 9. AGE (In years last birthday) 49 yrs | | 10. IF UNDER 1 YEAR Months 49 | |
| 11. IF UNDER 24 HRS Days 49 | | 12. IF UNDER 24 HRS Hours 49 | |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 14. KIND OF BUSINESS OR INDUSTRY Painting | |
| 15. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 16. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 17. FATHER'S NAME John P. Frank | | 18. MOTHER'S MAIDEN NAME Catherine Kleiderlein | |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 20. SOCIAL SECURITY NO 213-03-6845 | |
| 21. INFORMANT VAH, Baltimore 18, Maryland | | 22. ADDRESS FORT HOWARD DIVISION | |
| 23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA OF RIGHT UPPER LUNG AND HYPOPHARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| 24. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 25. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 26. I certify that (1) (this hospital) attended the deceased from Sept. 19 1960 to Oct. 19 1960 , that (2) (we) last saw the deceased alive on Oct. 19 1960 , and that death occurred at 10:30 P. M. , from the causes and on the date stated above | | | |
| 27. 22a. SIGNATURE Frederick S. Donaldson M.D. 22b. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. 22c. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION 22d. DATE SIGNED 10/20 | | | |
| 28. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/24/60 23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat 23d. LOCATION (City, town, or county) (State) Baltimore Md | | | |
| 29. 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus ADDRESS 305744 1st Rd 25a. REC'D BY REGISTRAR DATE OCT 21 1960 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

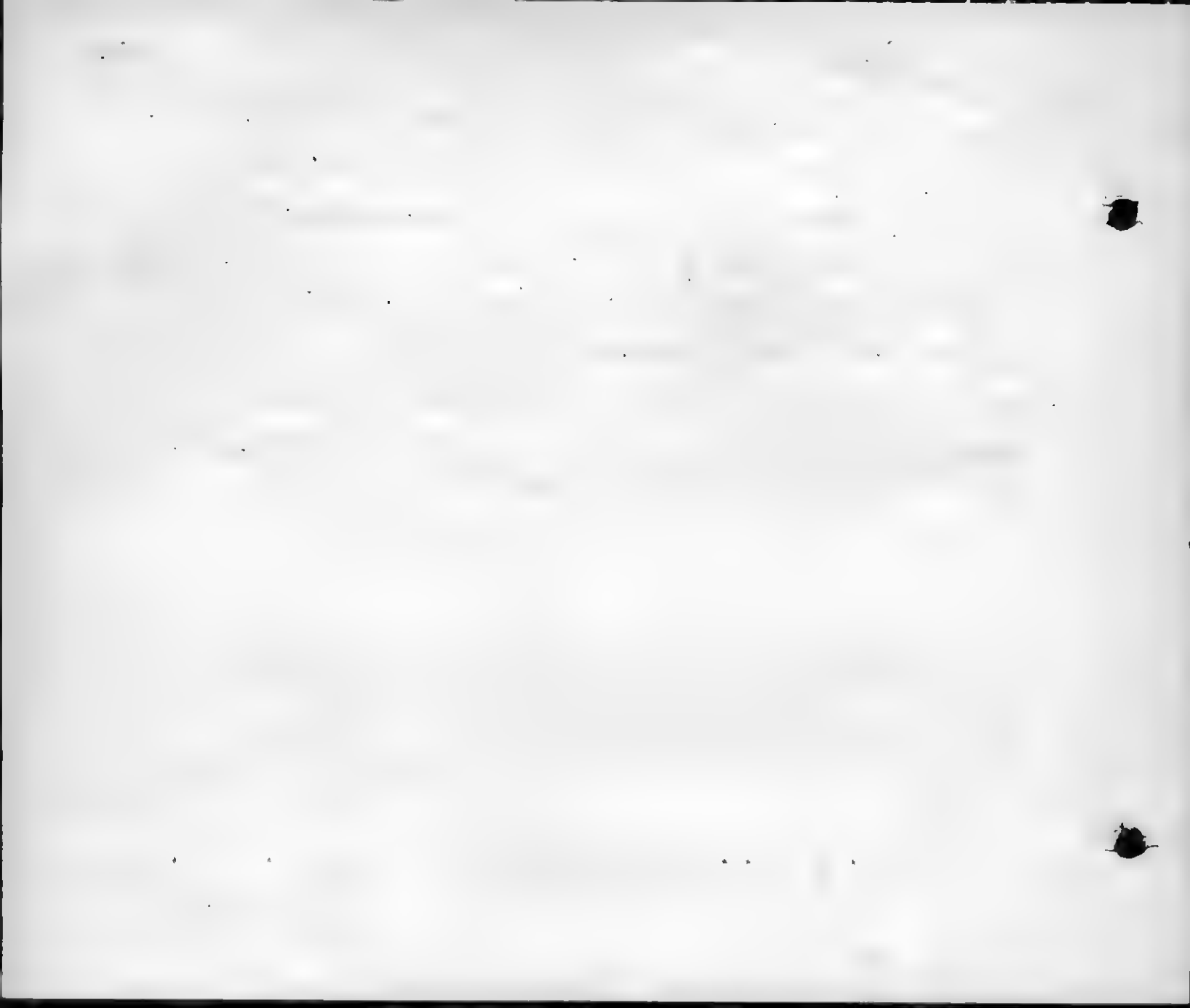
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11066

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|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1048 Lakemont Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>FRANK EDW. FRANKLIN</u> | | 4. DATE OF DEATH <u>Oct. 23 1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 12, 1911</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>guard</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James B. Franklin</u> | | 14. MOTHER'S MAIDEN NAME <u>Norah Brooks</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>Carolyn F. Franklin</u> | |
| 17. INFORMANT <u>Carolyn F. Franklin</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>coronary insufficiency</u> DUE TO (c) <u>?</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1950</u> to <u>23 Oct 1960</u> that (I) (we) last saw the deceased alive on <u>25 Oct 1960</u> and that death occurred at <u>4 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James E. Rowe</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe, M.D.</u> | | 22d. ADDRESS <u>1011 Frederick Ave. 28, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/26/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u> | | 23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>MacNab + Son</u> | | 25a. REC'D BY REGISTRAR <u>28</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | DATE <u>OCT 26 '60</u> | |



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY *Balto. Co.* MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Catonsville*
c. LENGTH OF STAY IN b. *6 yrs.*
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Balto. Md.*
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *Caton Ridge Conv. Home*
e. STREET ADDRESS *1740 Homestead St.*
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE *Md.* b. COUNTY *1034444444444444*

3. NAME OF DECEASED (Type or print) First Middle Last
Wm. Geary
4. DATE OF DEATH Month Day Year
Oct. 2 1960

5. SEX *male* 6. COLOR OR RACE *white* 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH *9/20/81* 9. AGE (In years lost birthday) *79* yrs. IF UNDER 1 YEAR Months Days Hours Min
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Clerk* 10b. KIND OF BUSINESS OR INDUSTRY *Md.* 11. BIRTHPLACE (State or foreign country) *Md.* 12. CITIZEN OF WHAT COUNTRY? *U.S.A.*

13. FATHER'S NAME *John Geary* 14. MOTHER'S MAIDEN NAME *Vain*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *no* 16. SOCIAL SECURITY NO. *no* 17. INFORMANT Address *Caton Ridge Records*

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Cardiac failure*
DUE TO *arterio sclerosis gen. coronary*
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost *Ar*
DUE TO (b) *Ar*
DUE TO (c) *Ar*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *Ar*
INTERVAL BETWEEN ONSET AND DEATH *1 1/2 weeks before*

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 *19* 20d. INJURY OCCURRED While ☐ of work Not while ☐ of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from *8/26* 19*57*, to *Oct* 19*60*, that (I) (we) last saw the deceased alive on *9/26* 19*60* and that death occurred at *3:30 P.M.* from the causes and on the date stated above

22a. SIGNATURE *Cliff Ratliff, Jr.* M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ 22b. ADDRESS *4605 EDMONDSON AVE #27* 22c. PHYSICIAN'S NAME (Type) *CLIFF RATLIFF, JR.* 22d. ADDRESS *4605 EDMONDSON AVE #27*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 23b. DATE THEREOF *10/5/60* 23c. NAME OF CEMETERY OR CREMATORY *Cathedral* 23d. LOCATION (City, town, or county) (State) *Balto. Md.*

24. FUNERAL DIRECTOR'S SIGNATURE *Wm. J. Smith + Son Jr* ADDRESS *28* 25a. REC'D BY REGISTRAR *OCT 6 '60* 25b. REGISTRAR'S SIGNATURE *Arthur S. Kline*



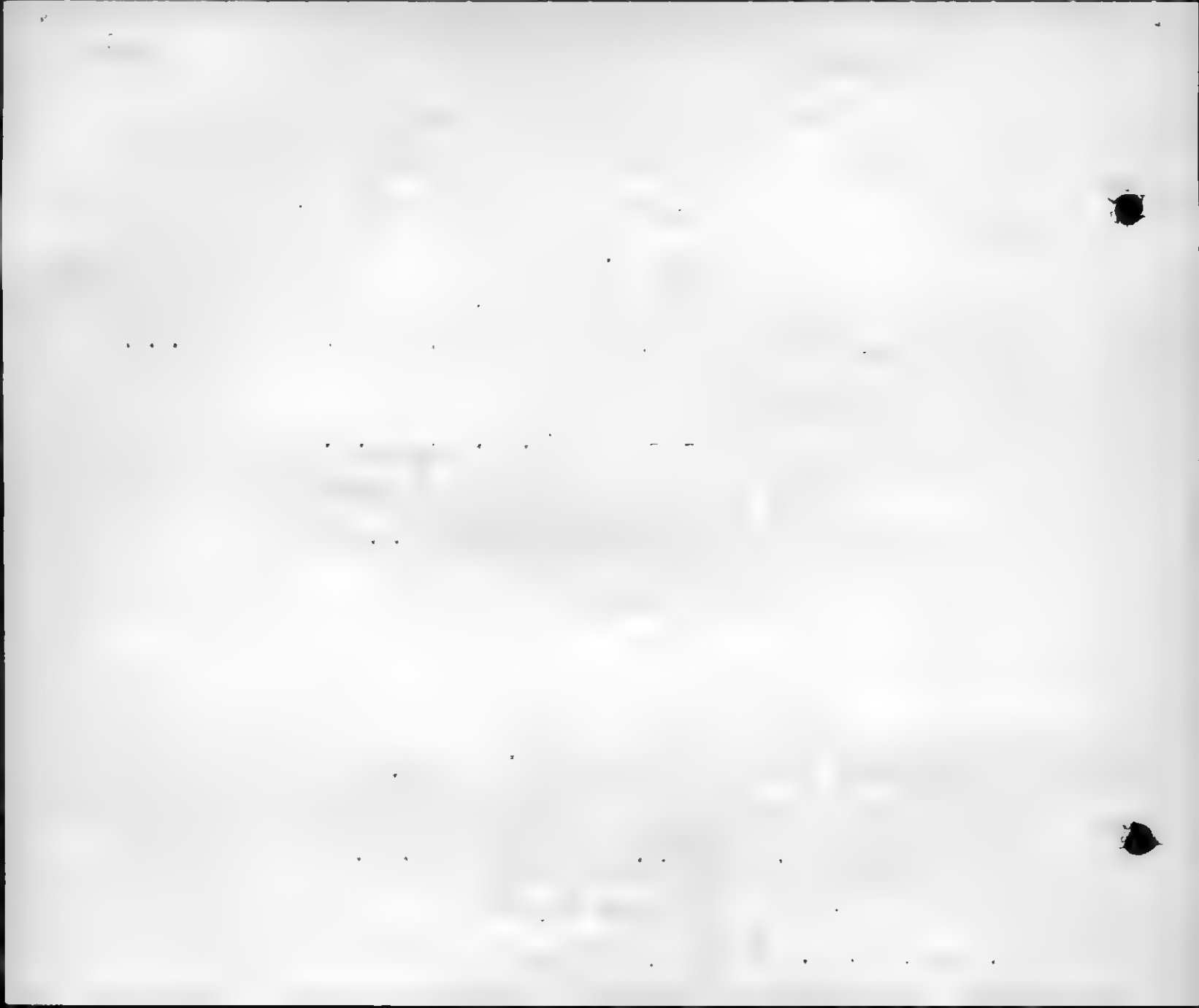
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 1 Day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. STREET ADDRESS 3901 Dorchester Road | | | |
| 3. NAME OF DECEASED (Type or print) ✓ First RAY Middle T. Last GEORGE | | | | 4. DATE OF DEATH Month OCTOBER Day 7 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/12/99 | |
| 9. AGE (In years lost birthday) 60 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Laundry | | 11. BIRTHPLACE (State or foreign country) Junior, West Virginia | |
| 13. FATHER'S NAME William George | | | | 14. MOTHER'S MAIDEN NAME Julia Corley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I | | | | 16. SOCIAL SECURITY NO 236-14-5429 | | 17. INFORMANT Address Clin.Rec.VAH, Balto.Md. Fort Howard Division | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH WITH METASTASIS TO REGIONAL LYMPH NODES AND LIVER Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (c) MASSIVE HEMORRHAGE INTO THE G.I. TRACT DUE TO (b) MASSIVE HEMORRHAGE INTO THE G.I. TRACT Interval Between Onset and Death UNKNOWN HOURS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that the (this hospital) attended the deceased from Oct. 6 19 60 to October 7 19 60 , that we (we) lost saw the deceased alive on October 7 19 60 , and that death occurred at 3P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Arthur T. Faulk | | | | 22b. DATE SIGNED 10/8/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D. | | | | 22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-11-60 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. | | | | 25a. REC'D BY REGISTRAR DATE OCT 11 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be re-issued by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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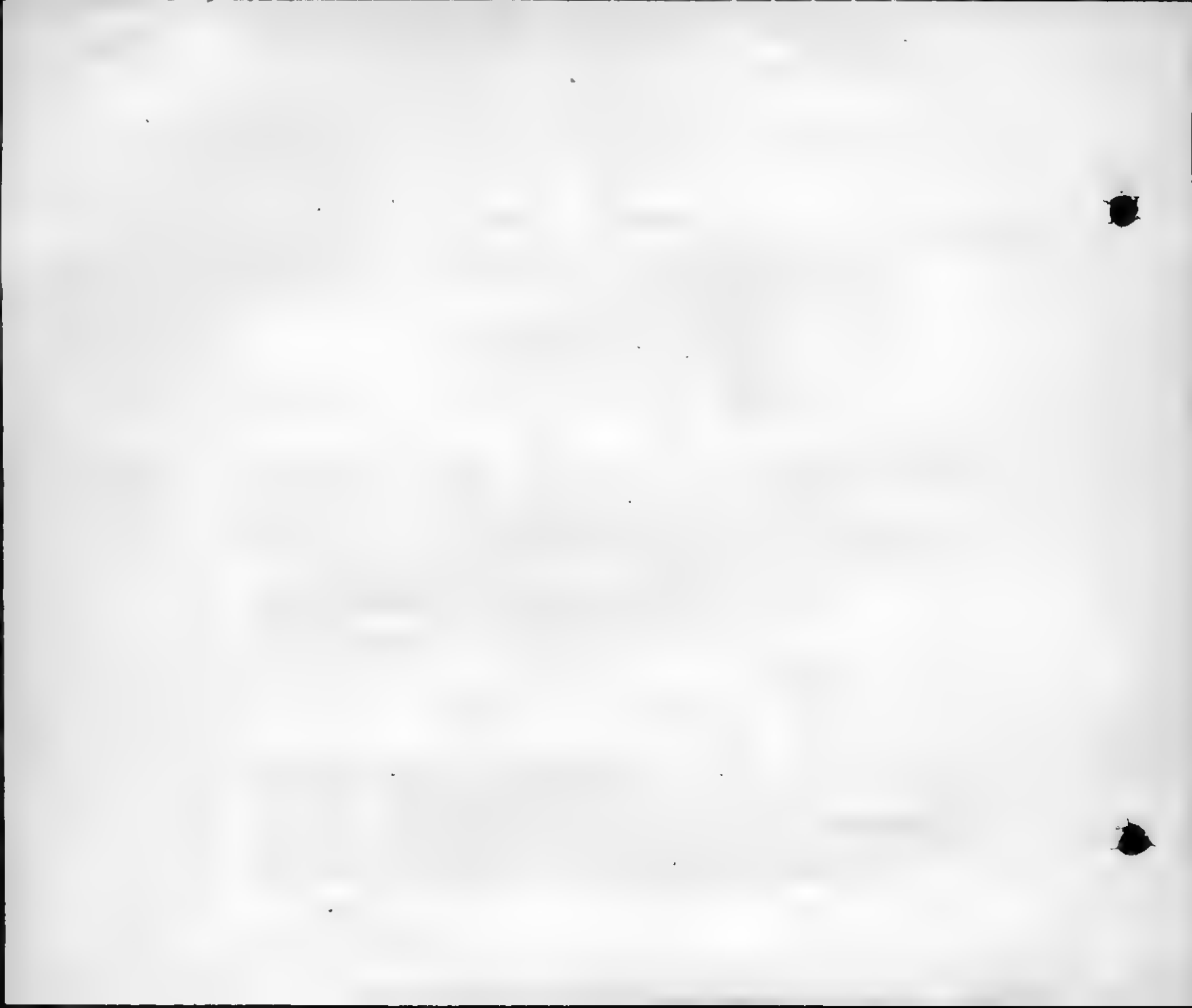
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11069

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> | | | | c. LENGTH OF STAY IN 1b <u>55</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TOWSON CONVALESCENT HOME</u> | | | | d. STREET ADDRESS <u>422 YORK ROAD</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE ESTELLA GERMAN</u> | | | | 4. DATE OF DEATH Month Day Year <u>OCTOBER 24 1960</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JULY 23, 1875</u> | |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>CHARLES BOSLEY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY E. FREELAND</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>FAMILY RECORDS</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Left</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1960</u> to <u>Oct. 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 24, 1960</u> , and that death occurred at <u>530P</u> PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Laurence C. Post</u> | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <u>10/25/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u> | | | | 22d. ADDRESS <u>6805 York Rd. Baltimore 12 Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>OCT. 27, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u> | | 23d. LOCATION (City, town, or county) (State) <u>TOWSON, MARYLAND</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons, Towson, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>OCT 28 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles E. House</u> | |

(M)

(I)



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11090
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11070
CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | |
| c. LENGTH OF STAY IN 1b 8 1/2 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | | d. STREET ADDRESS 269 S. PUTOMAC ST | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LAWRENCE Middle W Last GILL | | 4. DATE OF DEATH Month OCT Day 11 Year 1960 | |
| 5 SEX M. | 6. COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-1-1872 |
| 9. AGE (In years last birthday) 88 yrs | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCOMOTIVE ENGINEER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOHN H GILL | | 14. MOTHER'S MAIDEN NAME MARTHA MCCOMAS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Frank R. Smith Jr. - Cockeysville, Md. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diagnosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-18 1960 to 10-11 1960 that (I) (we) last saw the deceased alive on 10-11 1960 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Walter T. Kees | | 22b. DATE SIGNED 10/11/60 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER T. KEES | | 22d. ADDRESS COCKEYSVILLE, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10-14-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City, town, or county) (State) Hagerstown, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | 25a. REC'D BY REGISTRAR OCT 13 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11091

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11071

| | | | | | | | |
|--|------------------------------|---|-------------------------------------|---|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Balto 7 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 7 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 7 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3523 Sussex Road | | | | d. STREET ADDRESS 3523 Sussex Rd Balto 7 Md | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Charles H. Gogel Jr. | | | | 4. DATE OF DEATH Month Day Year 10 11 1960 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-23-10 | | 9. AGE (In years last birthday) 49 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Metlab Co Phila, Pa | | 11. BIRTHPLACE (State or foreign country) Balto; Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles H. Gogel Sr. | | | | 14. MOTHER'S MAIDEN NAME Frances E. Fitzpatrick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 212-09-808 | | 17. INFORMANT Address Mrs. Teresa R. Gogel 3523 Sussex Rd Balto 7 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma, metastatic DUE TO (b) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs - 3 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-17 , 19 60 , to 10-11 , 19 60 that (I) yes last saw the deceased alive on 10-11 , 19 60 , and that death occurred at 11 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Wm Carl Eberling M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Carl Eberling M. D. | | | | 22d. ADDRESS 401 Medical Arts Bldg. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-15-60 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | | 23d. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers | | | | ADDRESS 8728 Liberty Rd Randallstown, Md. | | 25a. REC'D BY REGISTRAR DATE OCT 18 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Means | | | |

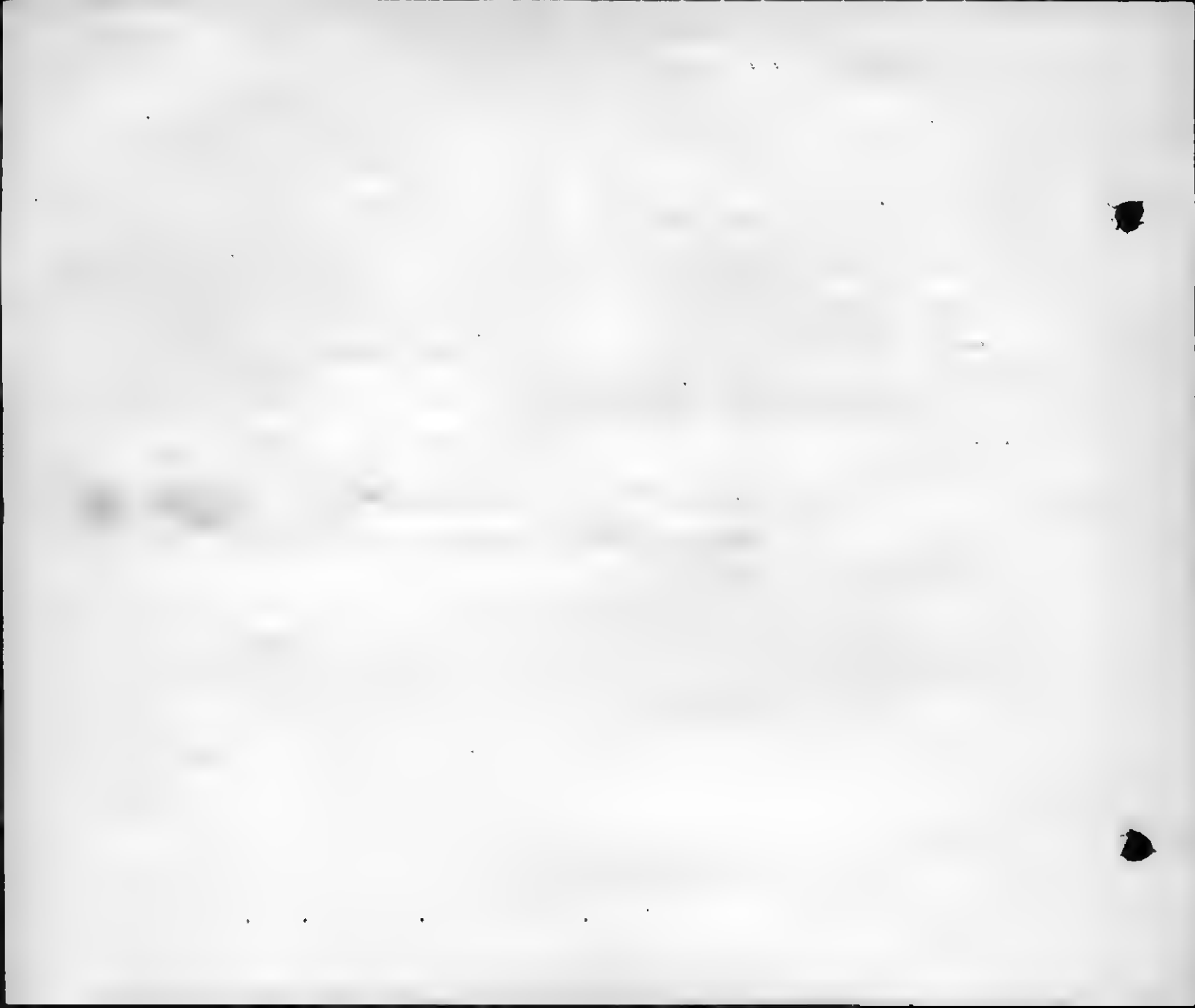


1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11092
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11072

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) QUINCE MILLS | | c. LENGTH OF STAY IN 1b 19 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 012 ROSEWOOD STATE TRAINING SCHOOL | | e. STREET ADDRESS 1617 SUNSHINE ST. | |
| 3. NAME OF DECEASED (Type or print) KENNETH LYNN GREINER | | 4. DATE OF DEATH OCTOBER 8 1960 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> | 8. DATE OF BIRTH OCTOBER 27, 59 |
| 9. AGE (In years lost birthday) 11 yrs | | 10. IF UNDER 1 YEAR 11 Months 11 Days 11 Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES EMIT GREINER | | 14. MOTHER'S MAIDEN NAME CATHERINE VIRGINIA FORHOFF | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) — (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT ROSEWOOD RECORDS | | Address — | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 752X IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO SEVERE NON-COMMUNICATED HYDROCEPHALY Birth Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) — DUE TO (c) — | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/7/60 to 10/8/60 , that (I) (we) last saw the deceased alive on 10/8/60 , and that death occurred at 6 P. M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Harry H. Butler MD | | 22b. DATE SIGNED 10/11/60 | |
| 22c. PHYSICIAN'S NAME (Type) Harry H. Butler MD | | 22d. ADDRESS Quince Mills, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/12/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem. | | 23d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Frank | | 25a. REC'D BY REGISTRAR Arthur S. Frank | |
| ADDRESS — | | DATE OCT 11 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Frank | | | |



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11093

11073

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point | | c. LENGTH OF STAY IN 1b X Sparrows Point | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 718 F Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Grupp, Sr. | | 4. DATE OF DEATH Month Day Year October 23, 1960 19 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Sept. 16, 1883 |
| 9. AGE (In years last birthday) 77 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottling Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY Brewery | |
| 11. BIRTHPLACE (State or foreign country) Penna | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph F. Grupp | | 14. MOTHER'S MAIDEN NAME Elizabeth Keifer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Mrs. Lillian Christian 718 F. Street-19 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Atherosclerotic Heart Disease Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from Jan. 1955 to Oct 23, 1960 , that (I) (the hospital) last saw the deceased alive on Oct 10, 1960 , and that death occurred at 10:25 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE R G WINDSOR | | 22b. DATE SIGNED 10-25-60 | |
| 22c. PHYSICIAN'S NAME (Type) R G WINDSOR | | 22d. ADDRESS 520 D St. BALT 19, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 27, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Moteland Memorial Park | | 23d. LOCATION (City, town, or county) (State) Parkville, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md. | | 25a. REC'D BY REGISTRAR OCT 27 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11094

11074

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u> | | c. LENGTH OF STAY IN 1b <u>14 Days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (14) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | | | d. STREET ADDRESS <u>7909 Elmhurst Avenue</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>R.</u> Last <u>HAGEN</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1893</u> | | 9. AGE (In years last birthday) yrs. <u>67</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Molder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Work</u> | | 11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Cornelius Hagen</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ella Grimes</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>WW I</u> | | 17. INFORMANT <u>Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEMORRHAGE, MASSIVE</u> DUE TO (b) <u>RUPTURE OF ESOPHAGEAL VARICES</u> <u>HEPATOMA MULTICENTRIC</u> (c) <u>PORTAL CIRRHOSIS OF LIVER</u> <u>METASTATIC CARCINOMA OF LIVER AND PANCREAS</u> 155.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>a. m.</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that <u>X</u> (this hospital) attended the deceased from <u>September 30, 1960</u> , to <u>October 14, 1960</u> , that <u>it</u> (we) last saw the deceased alive on <u>October 14, 1960</u> , and that death occurred at <u>1:00 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Frederick S. Donaldson</u> M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>10/14/60</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u> | | 22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10-17-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> | | | |
| | | | | 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> | | ADDRESS <u>5305 Harford Road, Balto. 14, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>OCT 18 '60</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Ruck</u> | | | | | | | |

850

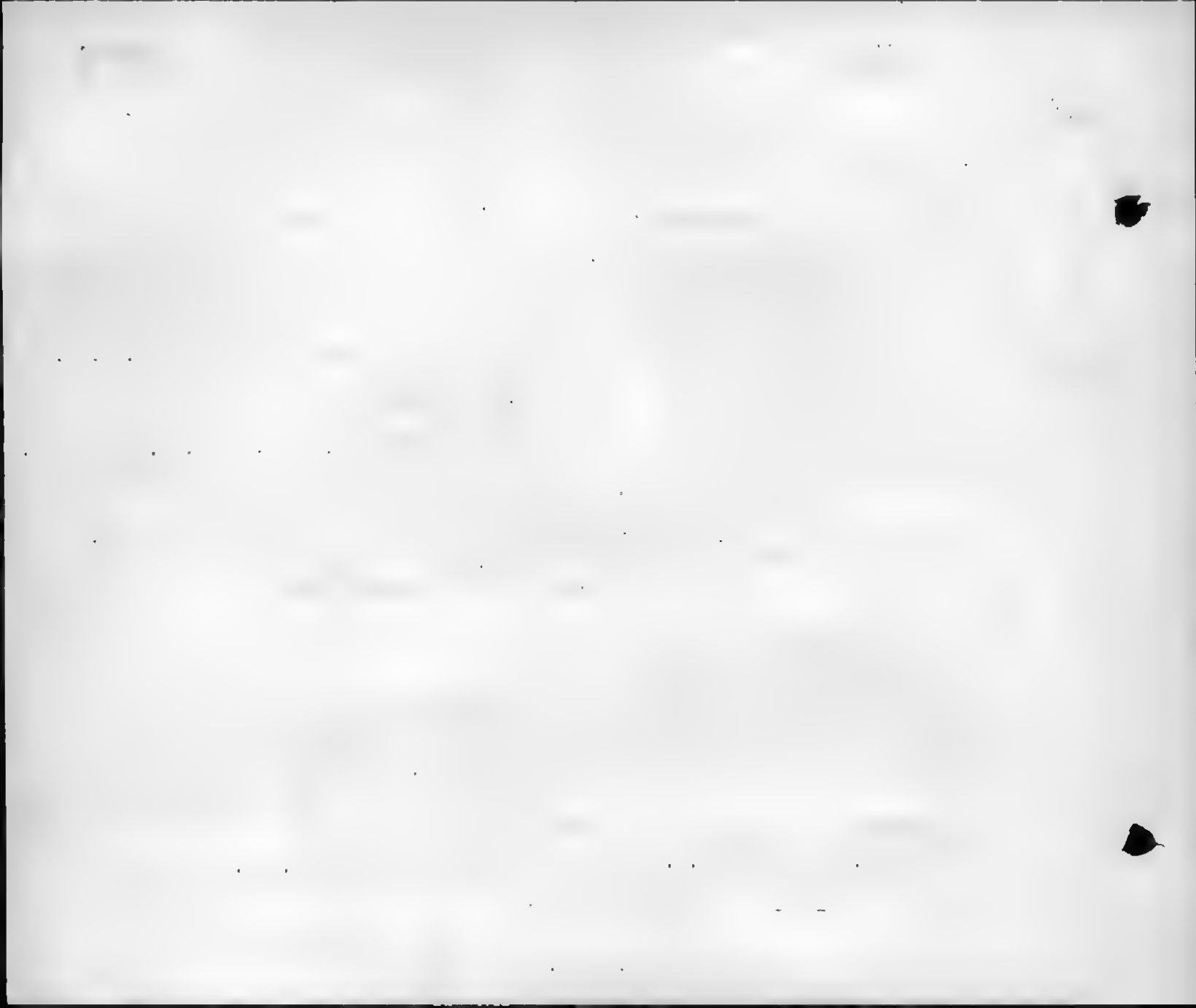
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11075

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u> c. LENGTH OF STAY IN 1b <u>6 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>36 BELFAST RD.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u> d. STREET ADDRESS <u>1 36 BELFAST RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>BARBARA</u> Middle <u>HALE</u> Last 4. DATE OF DEATH <u>OCT.</u> Month <u>17</u> Day <u>1960</u> Year | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-27-80</u> 9. AGE (In years last birthday) <u>80</u> yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u> 11. BIRTHPLACE (State or foreign country) <u>USA</u> | |
| 13. FATHER'S NAME <u>ELIJAH HALE</u> | | 14. MOTHER'S MAIDEN NAME <u>WHEELER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>219-20-5122</u> 17. INFORMANT <u>MRS. ALICE HALE</u> Address <u>36 BELFAST RD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> DUE TO <u>HANGING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>974X</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10-19-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>PINE GROVE</u> | | 22d. LOCATION (City, town, or county) (State) <u>RAYVILLE - BALTO. MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson</u> ADDRESS <u>TOWSON 4-MD</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | |
| 24a. REC'D BY REGISTRAR <u>OCT 18 '60</u> | | DATE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



11096

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

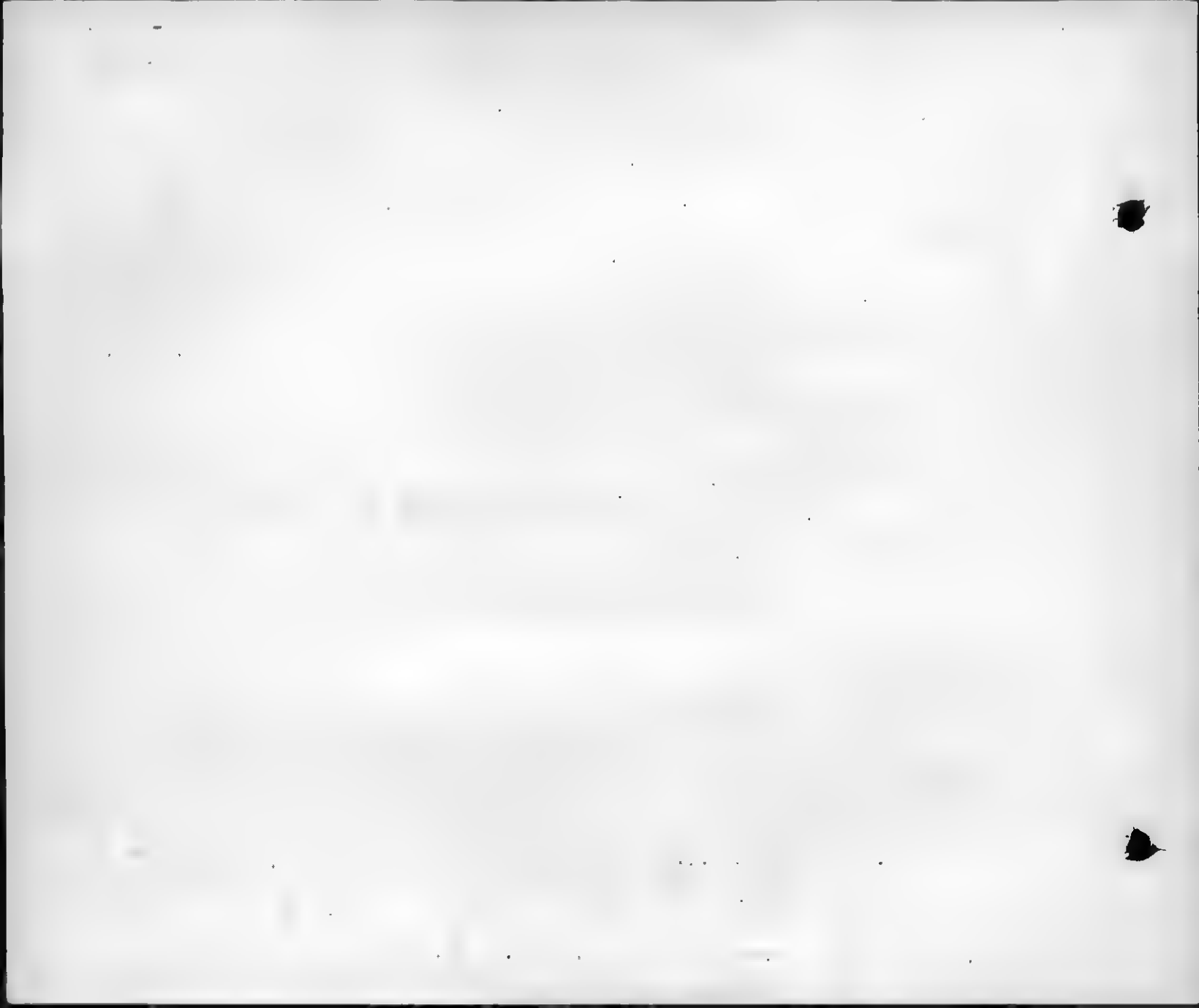
11076

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|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 44 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton d. STREET ADDRESS Silver Spring Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM J. HALLAMEYER | | 4. DATE OF DEATH Month Day Year October 26 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 8, 1902 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter | | 10b. KIND OF BUSINESS OR INDUSTRY Gas and Electric | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Frank Hallameyer | | 14. MOTHER'S MAIDEN NAME Anna Ruppert | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO WW II | |
| 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION | | 18. ADDRESS FORT HOWARD DIVISION | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT LUNG WITH METASTASES TO THE LUNGS, LEFT ADRENAL AND BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. EMPHYSEMA (c) ARTERIOSCLEROTIC HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from September 12, 1960 to October 26, 1960 , that (s) (we) last saw the deceased alive on October 26, 1960 , and that death occurred at 3:30 A. M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Walter J. Pijanowski | | 22b. DATE 10/26/60 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D. | | 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 10-28-60 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-/Blight, Inc. 6009 Harford Rd. Balto. 14, Md. | | 25a. REC'D BY REGISTRAR NOV 1 '60 | |
| 25b. REGISTRAR'S SIGNATURE Charles L. Hume | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached from this certificate as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11097

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11077

| | | | |
|--|----------------------------------|--|------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHADY NOOK NURSING HOME | | e. STREET ADDRESS 126 COLLEGE AVE | |
| 3. NAME OF DECEASED (Type or print) First Middle Last SOPHIA COOK HAMMOND | | 4. DATE OF DEATH Month Day Year OCT. 27, 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH |
| 9. AGE (In years lost birthday) 84 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMBROIDRY | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME FRANK LLOYD HAMMOND | | 14. MOTHER'S MAIDEN NAME FANNIE MARIA COOK | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT MISS ELEANOR M. HAMMOND | | Address 126 COLLEGE AVE. ELLICOTT CITY, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) Arteriosclerotic Cardio - Vascular Disease | | INTERVAL BETWEEN ONSET AND DEATH 5 days 4 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I None | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 10, 1956 to October 27, 1960 that (I) (we) last saw the deceased alive on October 27, 1960 and that death occurred at 3 P.M. from the causes and on the date stated above | | | |
| 22a. SIGNATURE William F. Gassaway | | 22b. DATE SIGNED 10/27/60 | |
| 22c. PHYSICIAN'S NAME (Type) William F. Gassaway M. D. | | 22d. ADDRESS Ellicott City, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10/27/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEM. | | 23d. LOCATION (City, town, or county) (State) ELLICOTT CITY, MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ELEANOR M. HAMMOND | | 25a. REC'D BY REGISTRAR OCT 31 '60 | |
| ADDRESS CATONSVILLE, MD. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be refiled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11098

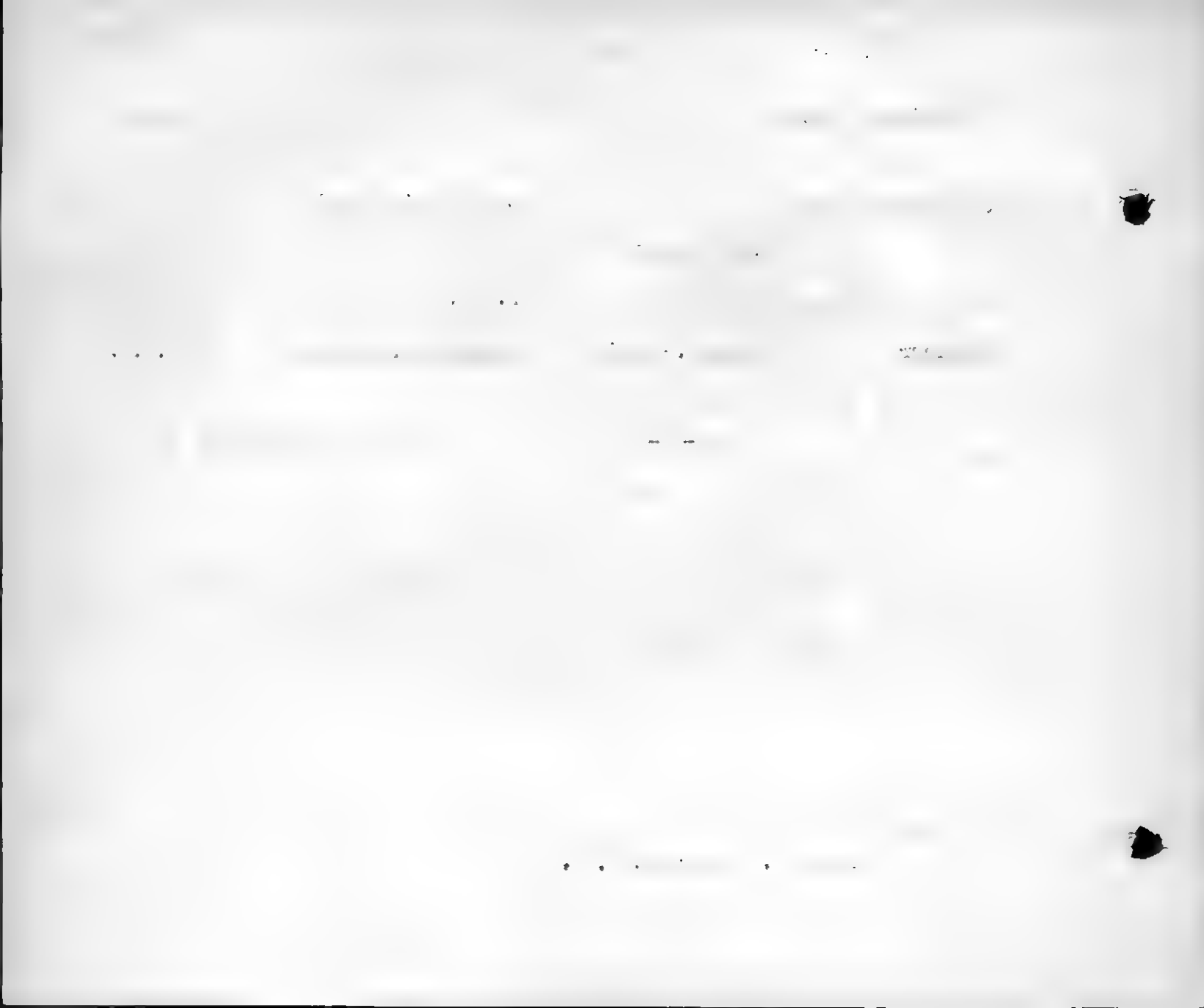
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11078

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore County | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 | | c. LENGTH OF STAY IN lb Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3400 Puttyhill Road | | d. STREET ADDRESS 3400 Puttyhill Road | | | | | |
| 3. NAME OF DECEASED (Type or print) JOSEPH HANLON | | First Middle Last | | 4. DATE OF DEATH Month Day Year 10 16TH 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 12, 1900 | | 9. AGE (In years last birthday) 60 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY Manfg.-Bedding | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DENNIS HANLON | | 14. MOTHER'S MAIDEN NAME MARY WALDON | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 216-03-4789 | | INFORMANT Wife | | Address 3400 Puttyhill Road #14 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA. 153-3 DUE TO Conditions, if any, which gave rise to immediate cause (b) CARDIAC FAILURE cause (c), stating the underlying cause last. ADENOCARCINOMA OF SIGMOID AN METASTATIC CARCINOMA - 16 MOS. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days " " | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JUNE 15, 1959 to OCT. 16, 1960 that I last saw the deceased alive on OCT. 16, 1960 , and that death occurred at 11:50 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Albert R. Wilkerson | | ADDRESS (Street, city or town, state) M.D. 1200 ST. PETER ST. BALTO - 2, MD 10/18/60 | | | | | |
| PHYSICIAN'S NAME (Type) Albert R. Wilkerson, M. D. | | DATE SIGNED | | | | | |
| 22a. BURIAL, CREMATION, OR REINTERMENT (Specify) BURIAL | | 22b. DATE THEREOF 10/20/60 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | 22d. LOCATION (City, town, or county) (State) BALTO MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. F. EVANS JR | | | | ADDRESS 8802 HARFORD RD | | 24a. REC'D BY REGISTRAR DATE OCT 20 '60 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

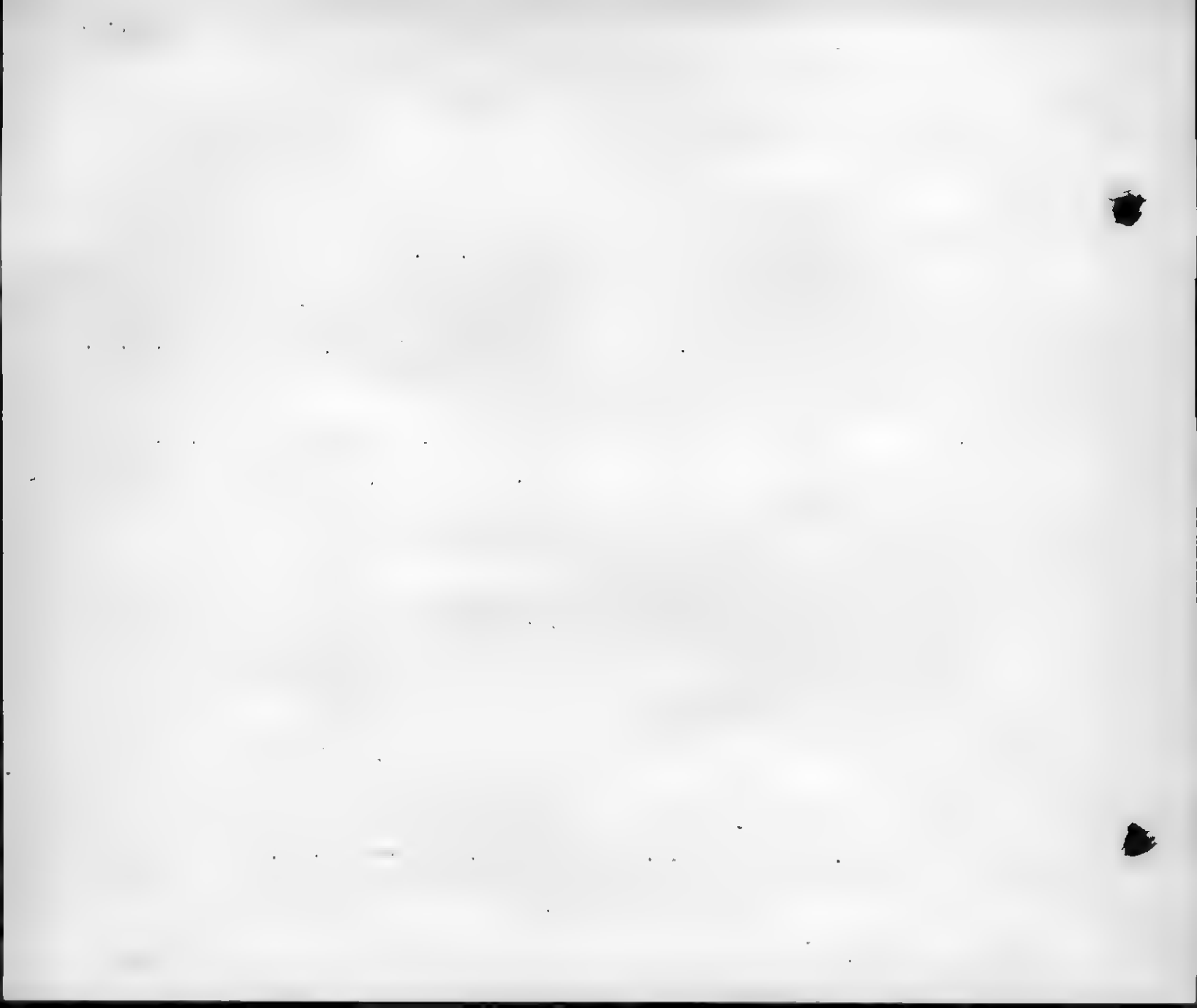


may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11079

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|--|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | | | c. LENGTH OF STAY IN 1b 3 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle --- Last HARRIS, JR. | | | | 4. DATE OF DEATH Month October Day 5 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 11, 1925 | 9. AGE (In years last birthday) yrs 35 | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | IF UNDER 24 HRS Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Harris, Sr. | | | | 14. MOTHER'S MAIDEN NAME Mammie Porter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 213-12-8631 | | 17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, MODERATELY ADVANCED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) BRONCHOPNEUMONIA, BILATERAL lying cause (c) PULMONARY EDEMA | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4+ DAYS 1 DAY |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FATTY INFILTRATION OF THE LIVER- Duration Unknown | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 2, 1960 to October 5, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 5, 1960 , and that death occurred at A. M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>Frederick S. Donaldson</i> | | | | 22b. DATE 10/6/60 | | 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-10-60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Kelson</i> | | | | 25a. REC'D BY REGISTRAR George G. Kelson, 1348 Calhoun St., Balto. Md. | | 25b. REGISTRAR'S SIGNATURE <i>George G. Kelson</i> | |



11100

CERTIFICATE OF DEATH

11080

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>York</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - White Hall RD 2</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Logansville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>75x-2</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Emma</u> Last <u>Hendrickson</u> | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 20, 1867</u> |
| 9. AGE (In years last birthday) <u>93</u> yrs. | | IF UNDER 1 YEAR: Months <u>2</u> Days <u>6</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House W. Sc.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Horse Shoe Run, W. Va.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Henry Sell</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Wotring</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Est. Crouse, White Hall RD #2</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiac Vas. Dis.</u> <u>422-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>10/24</u> 19 <u>60</u> , to <u>10/26</u> 19 <u>60</u> , that I last saw the deceased alive on <u>10/24</u> 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>PARKTON 10/26/60</u> | | | |
| ACTUAL SIGNATURE <u>C. Herbert Mueller</u> M.D. | | PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER, Jr.</u> MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Oct 28, 1960</u> | <u>Mt. Rose Cemetery</u> | <u>York Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Goodling, Seven Valleys, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 31 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>C. S. H. H. H.</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

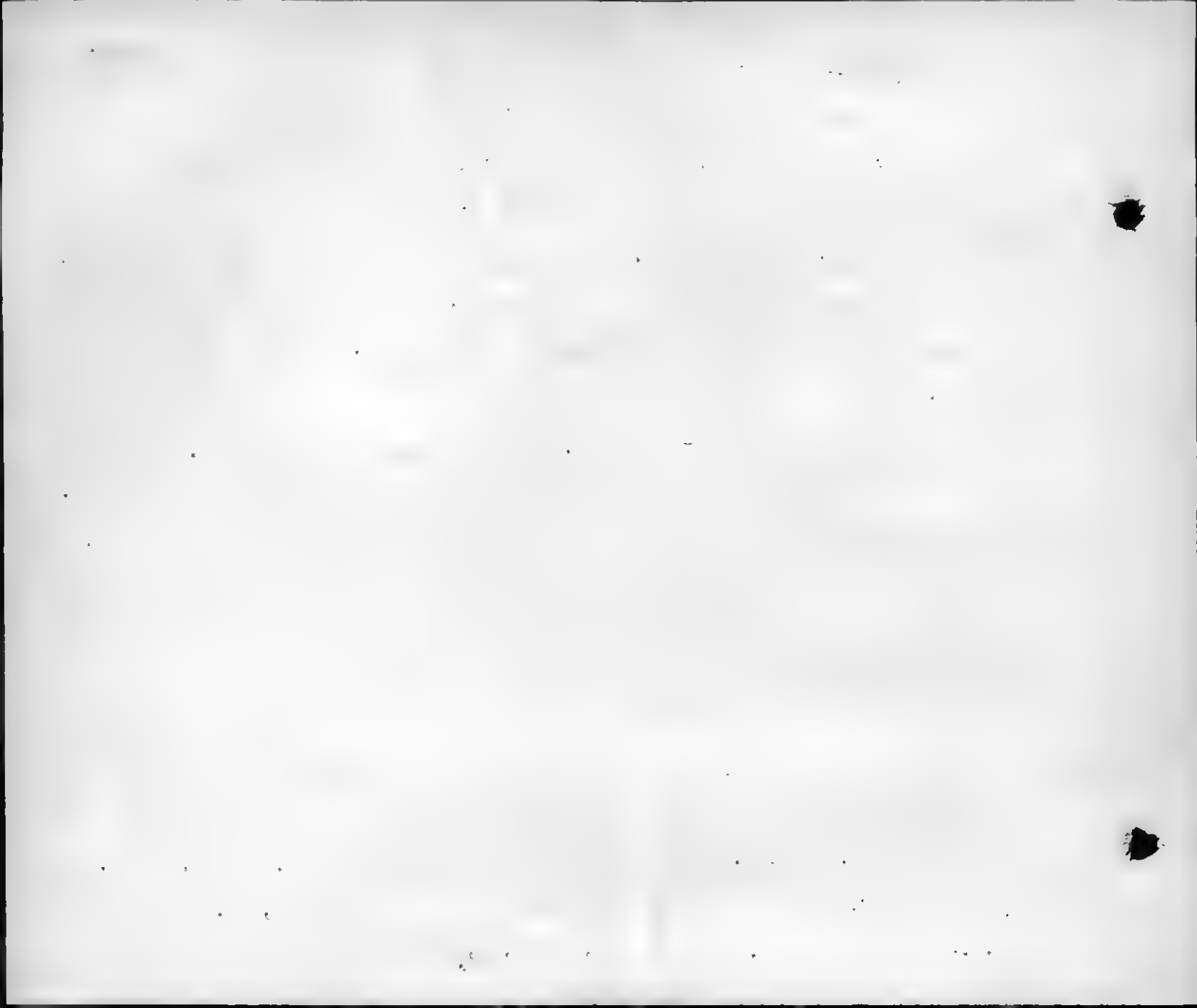


TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11101
11081
CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Middleburg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b 3 1/2 Months | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Larcy Villa | | d. STREET ADDRESS Fox Croft School | |
| 3. NAME OF DECEASED (Type or print) hebecca M. Hickok | | 4. DATE OF DEATH 10 20 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 2, 1891 |
| 9. AGE (In years last birthday) 69 yrs. | | 10. IF UNDER 1 YEAR: Months 8 Days 3 Hours X Min. 0 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 12. KIND OF BUSINESS OR INDUSTRY Fox Croft School | |
| 13. FATHER'S NAME John J. Hickok | | 14. MOTHER'S MAIDEN NAME Mary Ober | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 224-01-4964 | |
| 17. INFORMANT J. Hambleton Ober | | 18. ADDRESS 16 Elythewood Road Baltimore, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with hypertension DUE TO (c) 2 yrs. | | INTERVAL BETWEEN ONSET AND DEATH 6-8 mos. | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from 6-6-60 to 10-20-60 , that (I) (we) last saw the deceased alive on 10-20-60 , 19 60 , and that death occurred at 4:30 from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Warde B. Allan | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Warde B. Allan | | 22d. ADDRESS 6 E. Eager St., Balto. 2, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/22/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fox Croft Cemetery | | 23d. LOCATION (City, town, or county) (State) Middleburg, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd, Balto. 12 | | 25a. REC'D BY REGISTRAR OCT 24 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Thoms | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

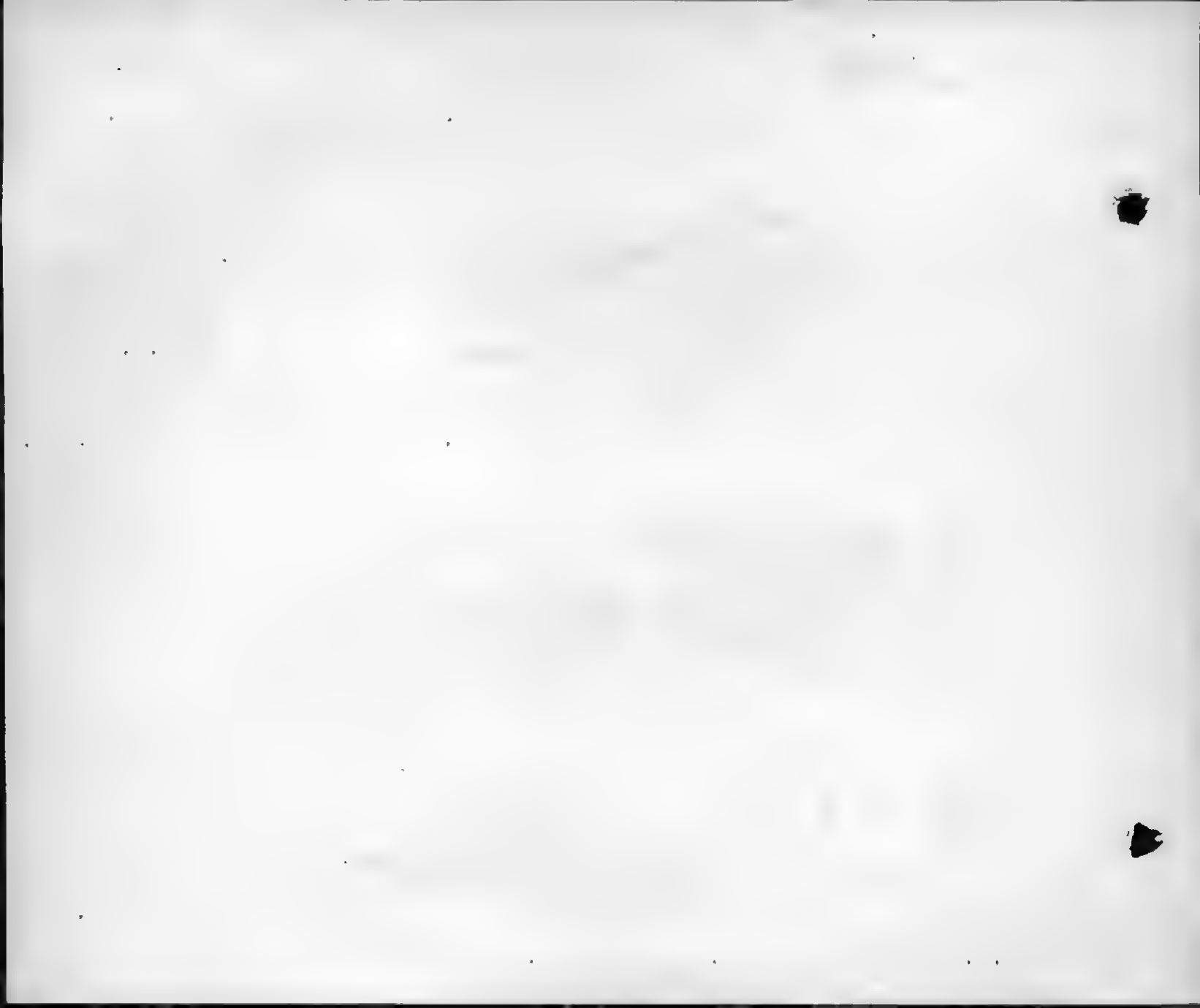
VR A) 5 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11102

11082

| | | | | | | | |
|---|------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mill | | | | c. LENGTH OF STAY IN 1b X Owings Mill | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chattolonee Hill | | | | e. STREET ADDRESS Chattolonee Hill | | | |
| 3. NAME OF DECEASED (Type or print) First Carolyn Middle Symington Last Hoffman | | | | 4. DATE OF DEATH Month Oct. Day 15 Year 1960 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 2 1870 | 9. AGE (In years last birthday) 90 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 13. FATHER'S NAME John Hopkins Jarney | | | 14. MOTHER'S MAIDEN NAME Caroline Symington | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO -- | | 17. INFORMANT William G. Hoffman 3rd Reisterstown, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerosis. DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 30 years | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 16 1936 to Oct 15 1960 that (I) (not) last saw the deceased alive on Oct 13 1960 and that death occurred at 10 PM , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Palmer F.C. Williams | | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) PALMER F.C. WILLIAMS | | | 22d. ADDRESS Pikesville Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-18-60 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 23d. LOCATION (City, town, or county) (State) Pikesville Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | 25a. REC'D BY REGISTRAR OCT 19 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kress | |



11103

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11083

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN lb 152 Days | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (13) d. STREET ADDRESS 2705 Pelham Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HERMAN W. HOFFMAN | | | | 4. DATE OF DEATH Month Day Year October 19 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 24, 1933 | 9. AGE (In years last birthday) 26 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min | 11. IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician | | 10b. KIND OF BUSINESS OR INDUSTRY Electronics | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Herman C. Hoffman | | | | 14. MOTHER'S MAIDEN NAME Emily King | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give year or date of service) 6/3/54; 5/25/56 218-30-5412 | | 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA, GENERALIZED 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC ADHESIVE PERICARDITIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) May 20 1960 | 20g. (County) (State) Oct. 19 1960 | | | |
| 21. I certify that (this hospital) attended the deceased from May 20 1960 to Oct. 19 1960 , that (we) last saw the deceased alive on Oct. 19 1960 , and that death occurred at 10:25 P. M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Fredrick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | | | 22b. DATE SIGNED 10/20/60 | | | |
| 22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Oct 24/60 | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, 4210 Belair Rd. Balto. Md. | | | 25a. REC'D BY REGISTRAR DATE OCT 24 '60 | | 25b. REGISTRAR'S SIGNATURE Christa S. Kneass | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



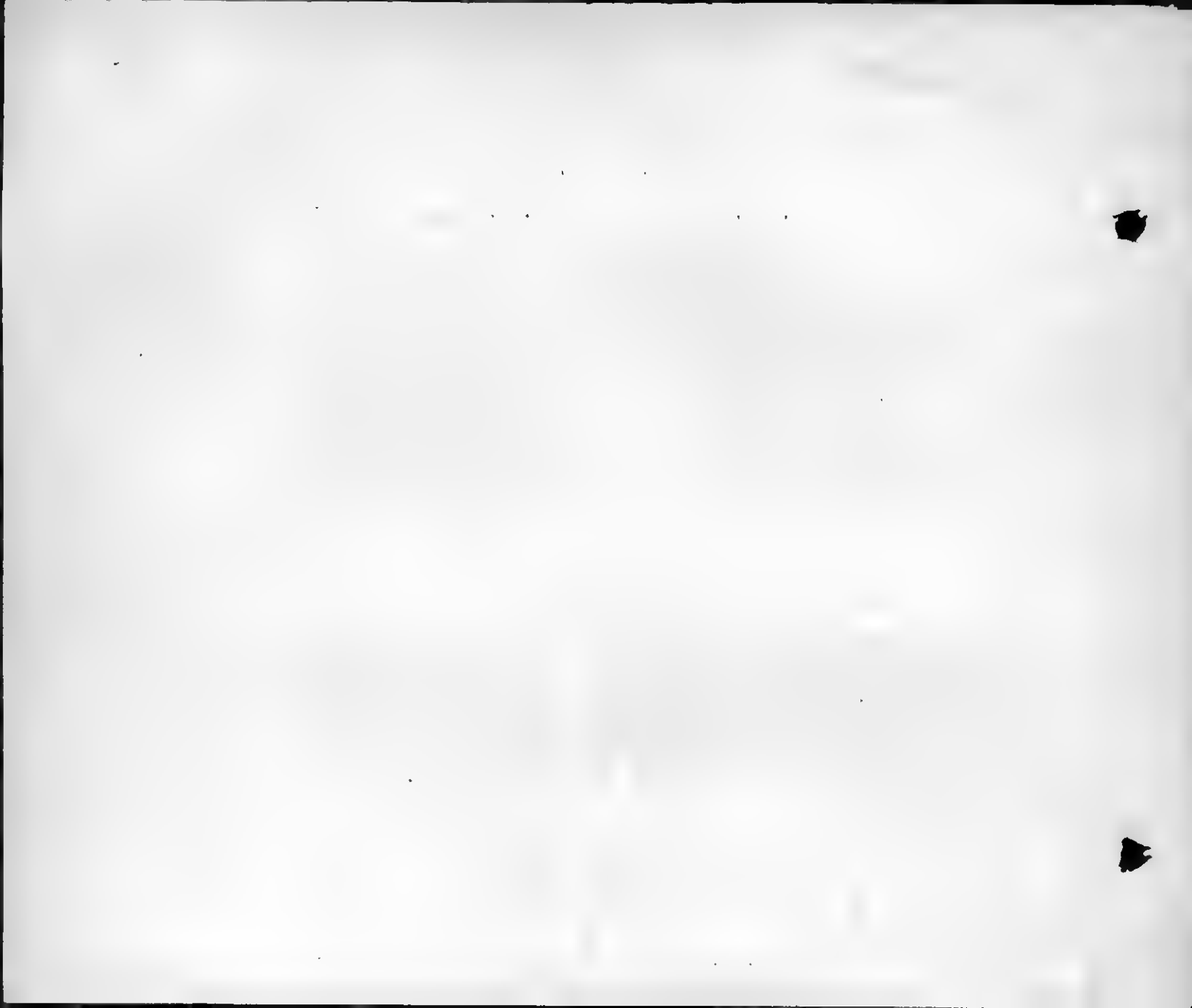
11104

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11084

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | c. LENGTH OF STAY IN 1b 1 mo. 21 da. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Tr. School | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland | |
| 3. NAME OF DECEASED (Type or print) First Louis Middle Wayne Last HOLLOWAY | | f. STREET ADDRESS P. O. box 485, 13 Morgan Street | |
| 4. DATE OF DEATH Month 10 Day 21 Year 19 60 | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/12/60 |
| 9. AGE (In years last birthday) 3 yrs. | | 10. IF UNDER 1 YEAR Month's 3 Days 9 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 12. KIND OF BUSINESS OR INDUSTRY | |
| 13. BIRTHPLACE (State or foreign country) Maryland | | 14. CITIZEN OF WHAT COUNTRY? U.S.A./ | |
| 15. FATHER'S NAME Roy Eugene Wilder | | 16. MOTHER'S MAIDEN NAME Anna Frances Holloway | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 18. SOCIAL SECURITY NO. no | |
| 19. INFORMANT Rosewood Records | | Address | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 752X IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10/21/60 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8/25 19 60 to 10/21 19 60 , that (I) (we) last saw the deceased alive on 10/21 1960 , and that death occurred at 9a M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Edward J. Matthews | | 22b. DATE SIGNED 10-21-60 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS Rosewood State Training School (Box 183) Owings Mills, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF Oct 27, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery | 23d. LOCATION (City, town, or county) (State) Owings Mills Md |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer, Mrs Rusttown | | 25a. REC'D BY REGISTRAR DATE NOV 1 '60 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Charles S. Hume | |

2071182XV4



FOR STATE
HEALTH DEPT.

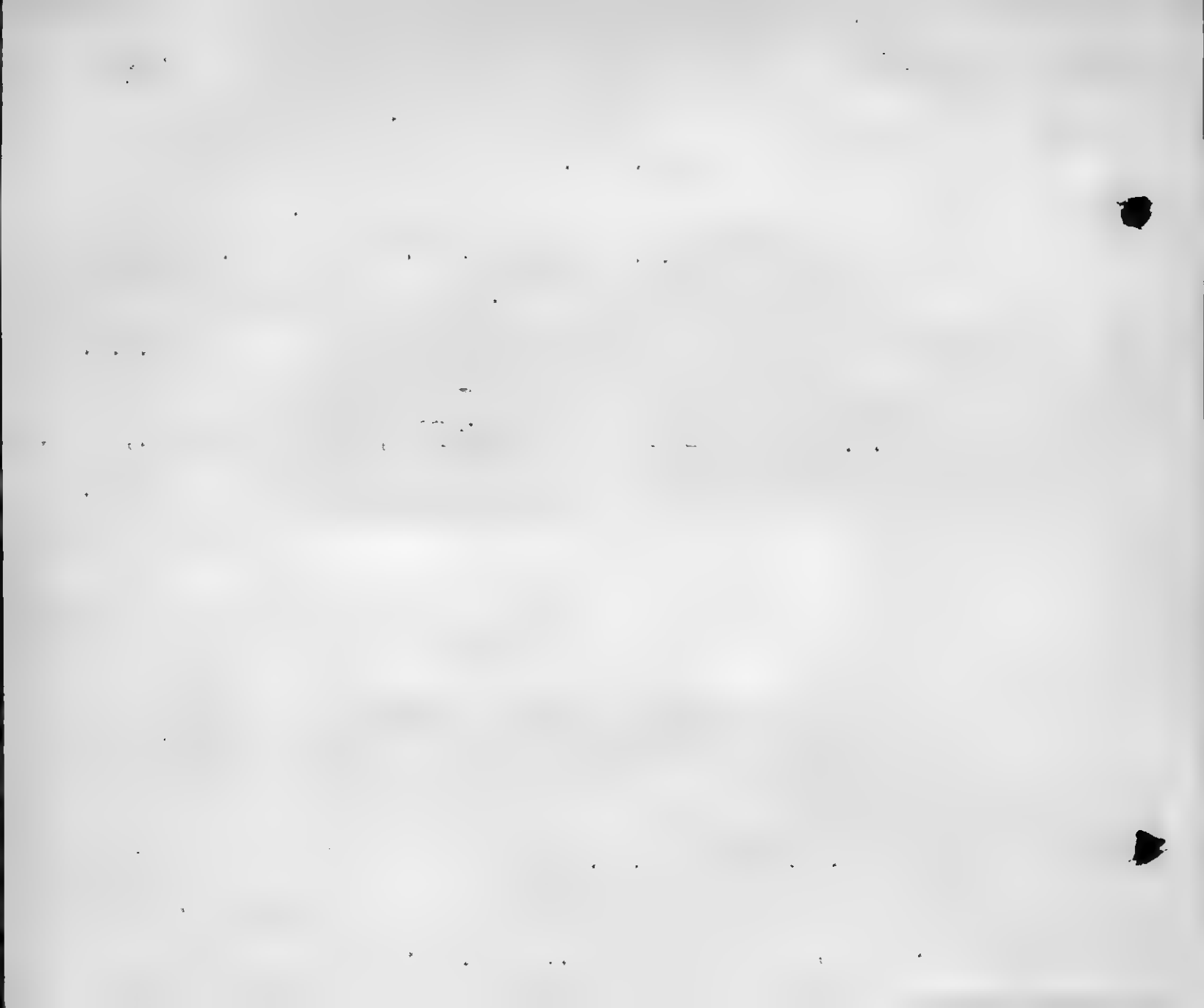
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McDonogh c. LENGTH OF STAY IN 1b 2 yrs. 8 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McDonogh School | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Ma. b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 2225 Orleans St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Robert B.T. Holmes, Jr. | | 4. DATE OF DEATH Oct. 3 1960 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 20, 1913 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10b. KIND OF BUSINESS OR INDUSTRY McDonogh School | 11. BIRTHPLACE (State or foreign country) South Carolina |
| 13. FATHER'S NAME Robert Holmes | | 14. MOTHER'S MAIDEN NAME Sarah Moore | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 218-07-3726 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) none | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. INTERVAL BETWEEN ONSET AND DEATH 1 mo. | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m. none | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work none | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) none (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE D. D. Caples | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/9/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt Talor Cemetary | | 22d. LOCATION (City, town, or country) Blackstork S.C. | |
| 23. FUNERAL DIRECTOR Elroy O. Wilson, 1000 Brentley Ave., Balto. | | 24a. REC'D BY REGISTRAR OCT 7 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | |

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

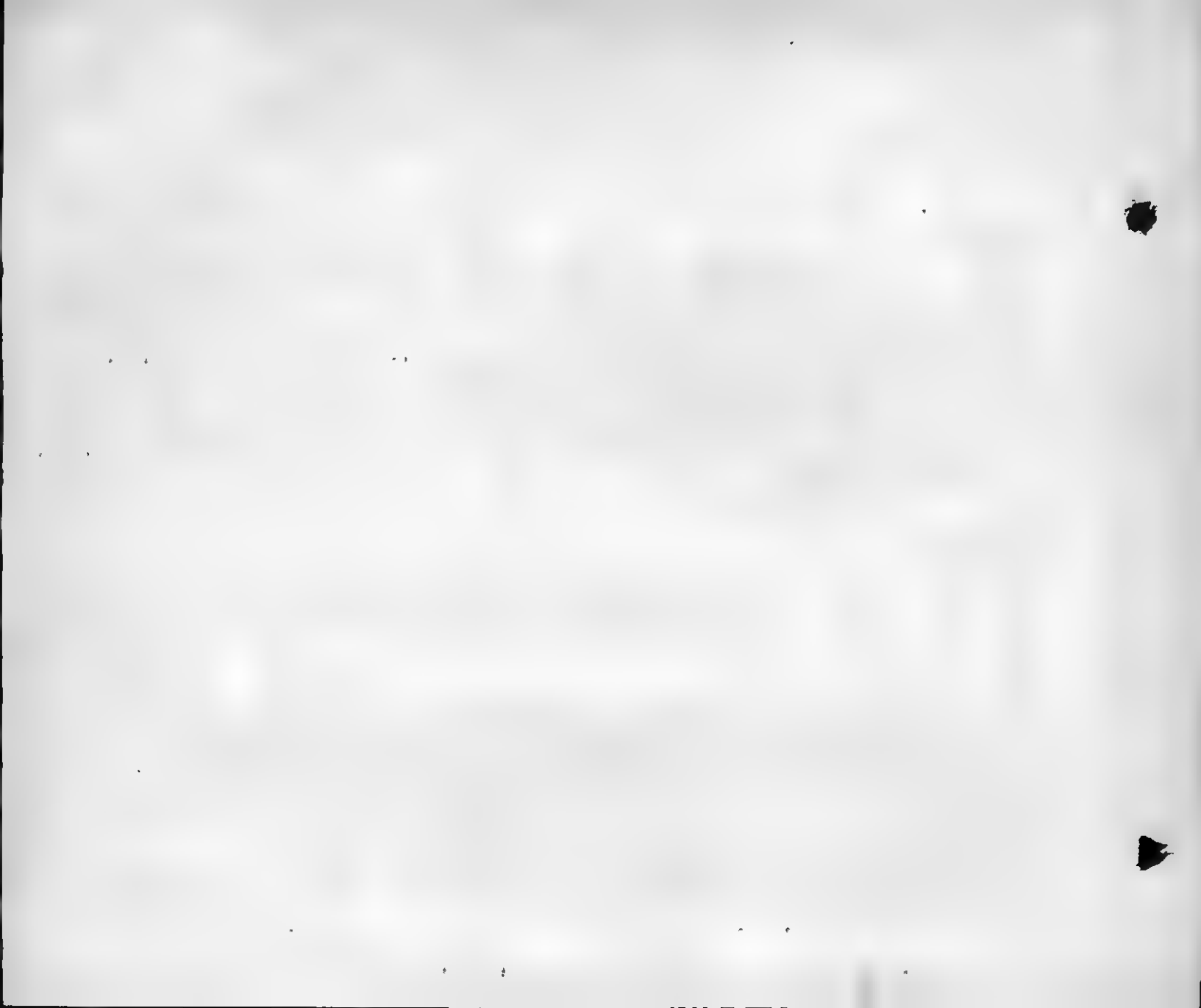
11106

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11086

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | c. LENGTH OF STAY IN 1b <u>14 years</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>115 E. Chesapeake Avenue</u> | | | | d. STREET ADDRESS <u>115 Chesapeake Avenue</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>James</u> <u>Holifield</u> | | | | 4. DATE OF DEATH Month Day Year <u>10</u> - <u>22</u> - <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>?</u> <u>1915</u> | |
| 9. AGE (In years last birthday) <u>45</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen Helper</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Perry Co., Alabama</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Jim Holifield</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO <u>212-30-4117</u> | | 17. INFORMANT Address <u>Luther Holifield 241 Silver Court Balto. Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>943 X</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>William A. Jackson</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 27, 60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u> | | 22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>William A. Jackson Funeral Home Inc. 916 Pa. Ave</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 10/22/60</u> | | 24b. REGISTRAR'S SIGNATURE | |

DATE SIGNED
10/23/60



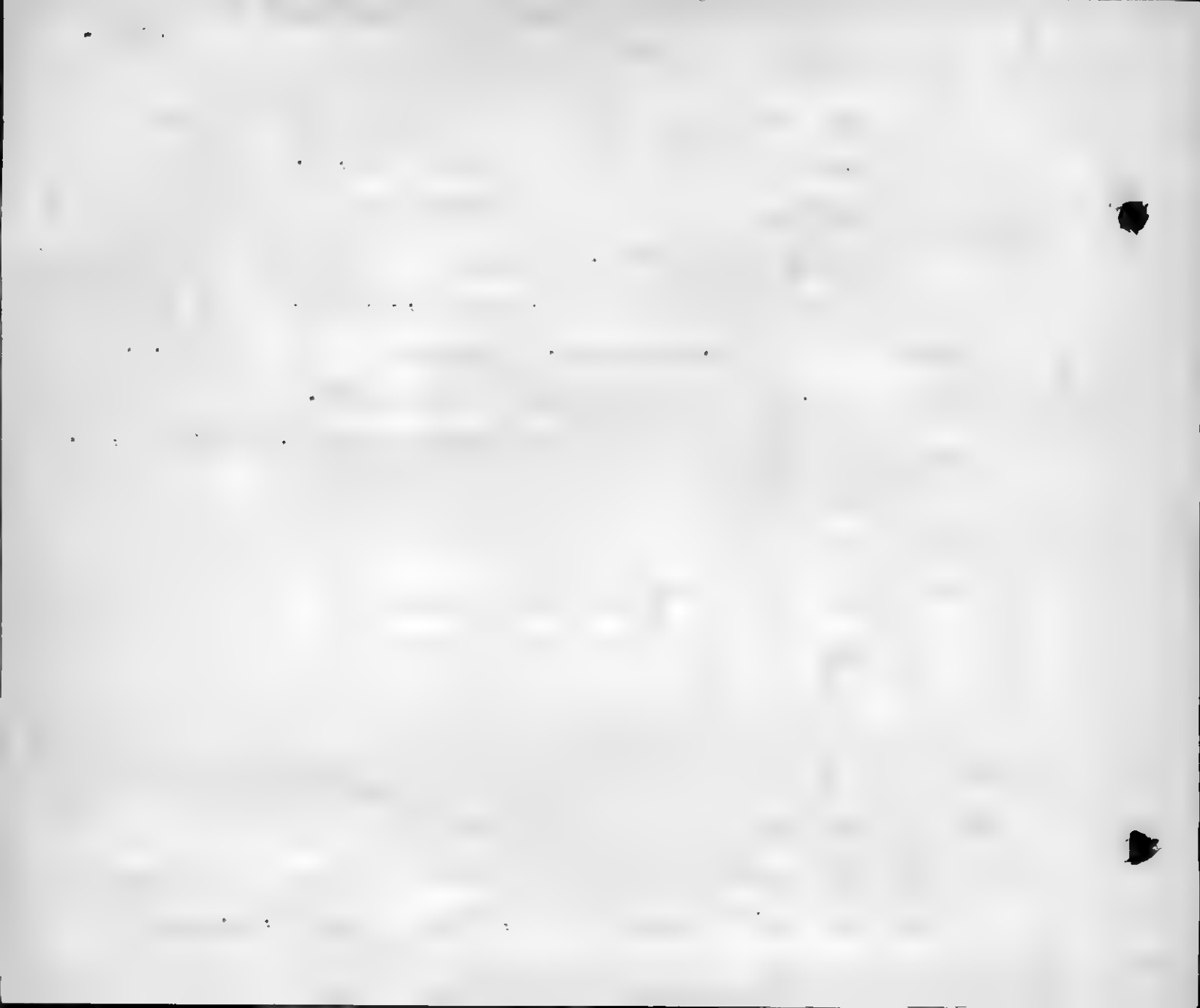
11107

CERTIFICATE OF DEATH

11087

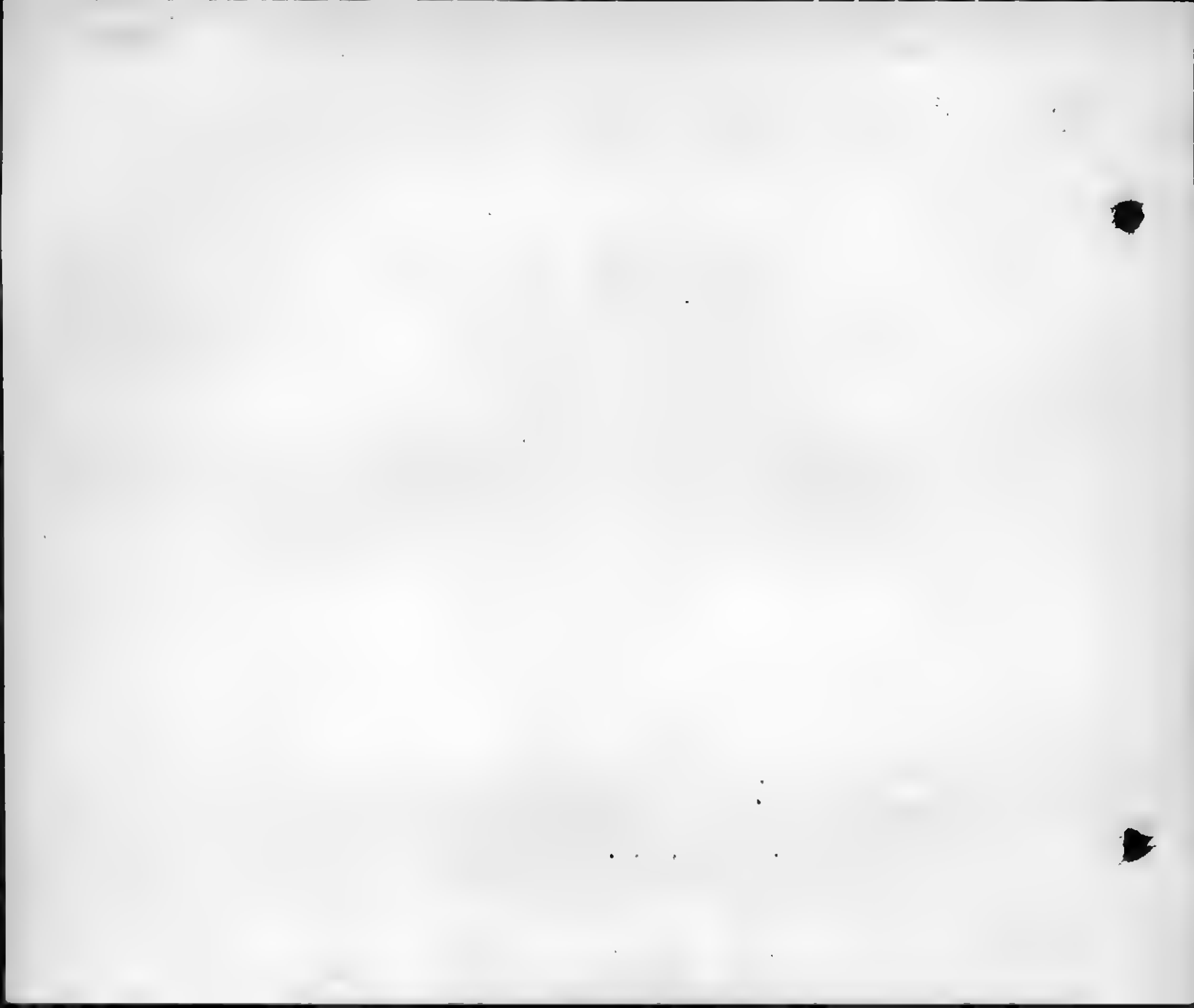
Reg. Dist. No.

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|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Ave | | d. STREET ADDRESS Ridgeway Ave | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Audrey Ruth Hoshall | | 4. DATE OF DEATH Month Day Year October 26, 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 16, 1919 |
| 9. AGE (In years last birthday) 41 yrs. | | IF UNDER 1 YEAR Months 2 Days 10 | IF UNDER 24 HRS. Hours 10 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner | | 10b. KIND OF BUSINESS OR INDUSTRY L.Grief Bros. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Harry Tracey. | | 14. MOTHER'S MAIDEN NAME Birdie Wilson. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT John Raymond Hoshall, Lutherville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sarcomatous of Uterus 174X DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) starvation | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I attended the deceased from August 1960 , to October 26, 1960 , that I last saw the deceased alive on October 26th, 1960 , and that death occurred at 2 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE George H. Gross | | DATE SIGNED Oct. 27, 1960 | |
| PHYSICIAN'S NAME (Type) George H. Gross | | M.D. 28 Waverly St | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/29/60 | 22c. NAME OF CEMETERY OR CREMATORY Stablersville, Md | 22d. LOCATION (City, town, or county) (State) Balto Co, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Schuman - 3818 Roland Ave | | 24a. REC'D BY REGISTRAR OCT 28 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Schuman | | | |



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|--|------------------------|--|---|
| 24. FUNERAL DIRECTOR'S SIGNATURE WM COOK-TOWSON, INC. | ADDRESS TOWSON 4 MD | 25a. REC'D BY REGISTRAR DATE OCT 18 '60 | 25b. REGISTRAR'S SIGNATURE <i>Ernest G. P. [Signature]</i> |
|--|------------------------|--|---|

VR A15 (4)
ISM 9/59

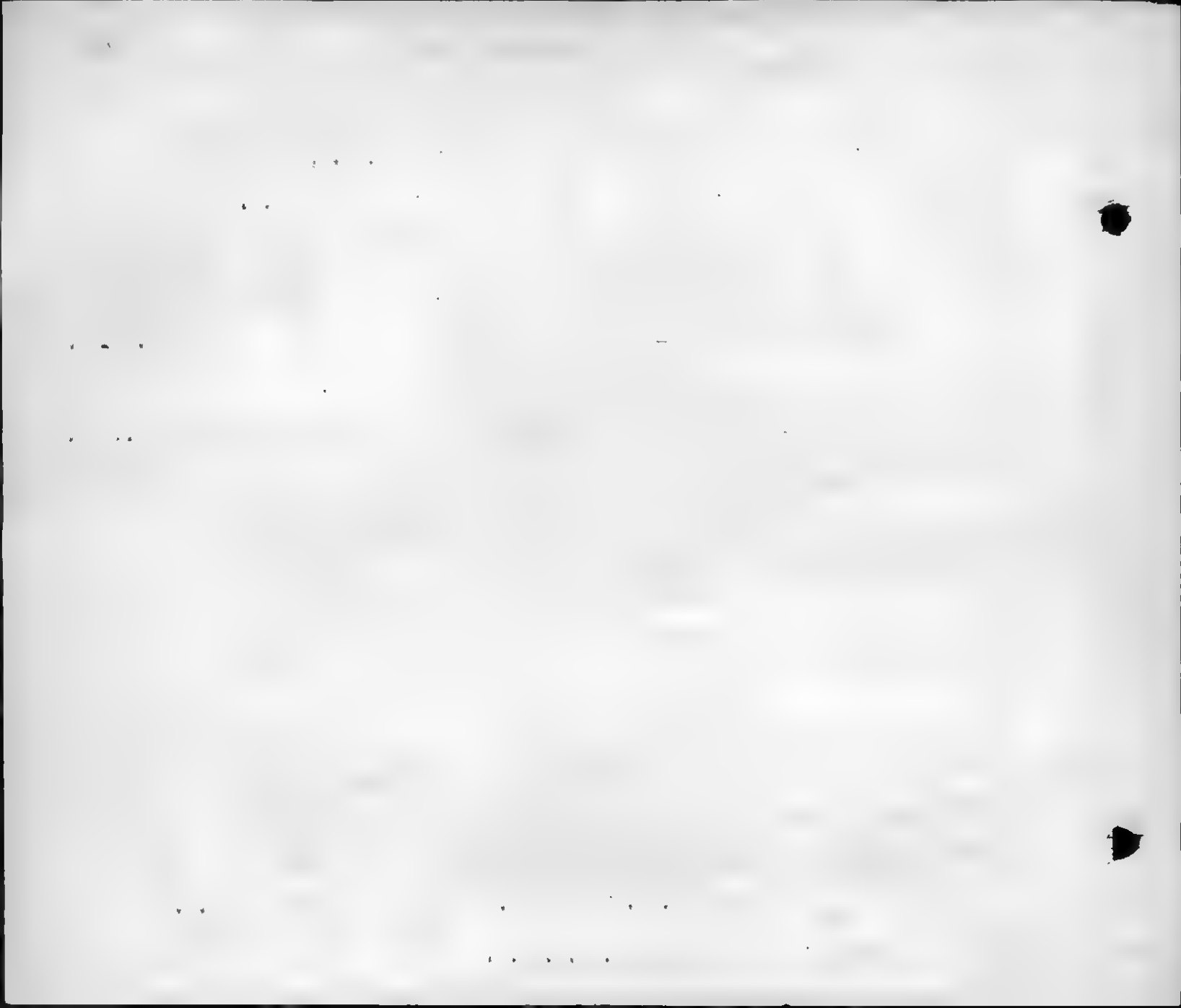


CERTIFICATE OF DEATH

Reg. Dist. No. 11089

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-2</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>3 months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Nursing Home</u> | | d. STREET ADDRESS <u>48 Madison Street N.W.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Aaron</u> <u>-</u> <u>Iskow</u> | | 4. DATE OF DEATH Month Day Year <u>10</u> <u>9</u> <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 16, 1878</u> |
| 9. AGE (In years last birthday) yrs. <u>82</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Moses Iskow</u> | | 14. MOTHER'S MAIDEN NAME <u>Dora</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>None</u> | |
| 17. INFORMANT <u>Herman Iskow</u> | | Address <u>10230 Conover Dr, SSpg., Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>44</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u>Renal Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5-27, 1960</u> to <u>10-9, 1960</u> , that I last saw the deceased alive on <u>10-8, 1960</u> , and that death occurred at <u>6:15 A.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Walter K. Gallagher</u> | | ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>10/9/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Walter K. Gallagher</u> | | <u>Baltimore-28</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct 10, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>D. C. Lodge Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> | | ADDRESS <u>4217 9th St. N.W., D.C.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hirsch</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



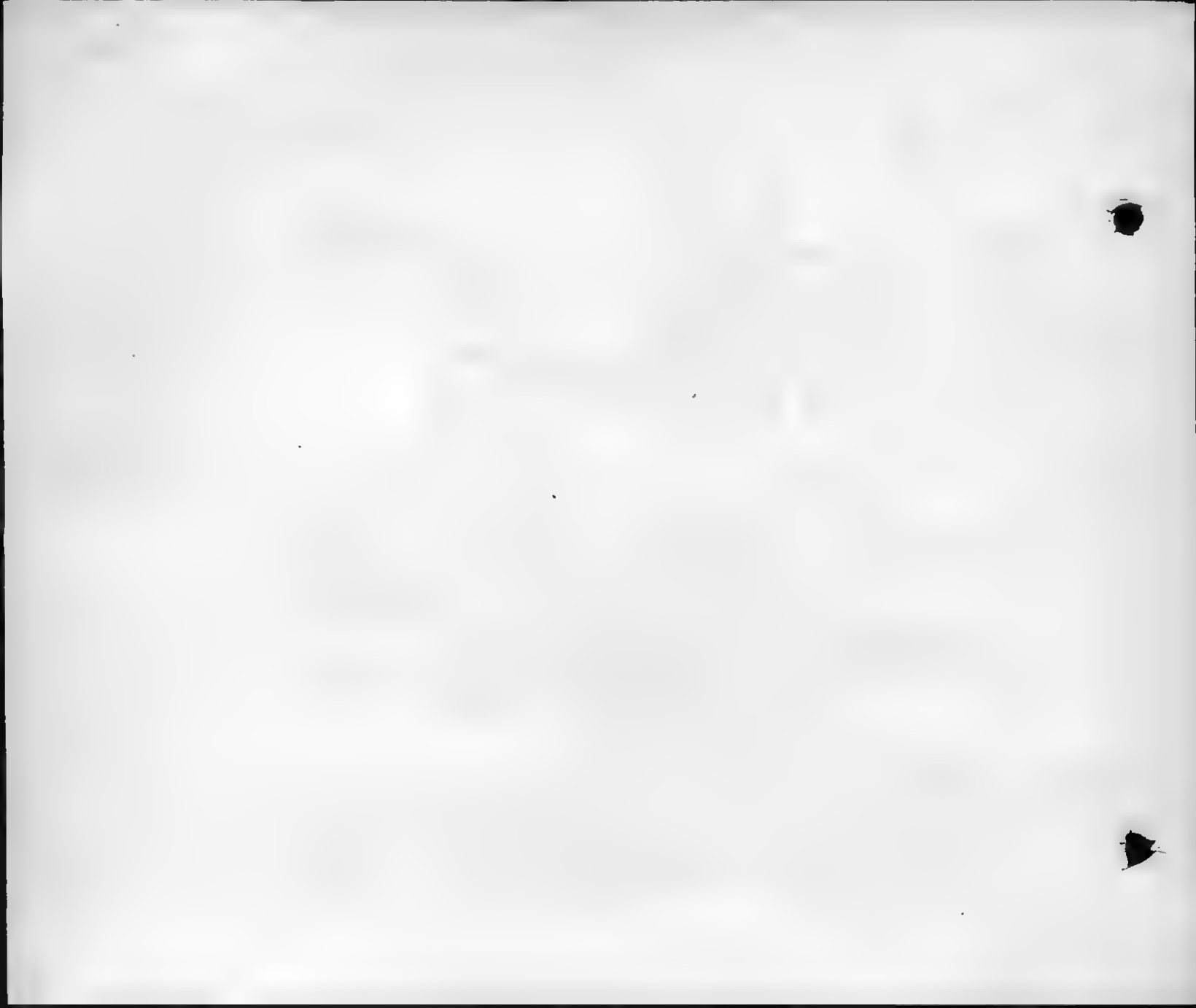
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11110
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11090

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|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River | | c. LENGTH OF STAY IN 1b Dundalk | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home | | d. STREET ADDRESS 1906 Jefferson Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle WILLIAM Last JOHN | | 4. DATE OF DEATH Month October Day 30 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1982 |
| 9. AGE (In years last birthday) 78 yrs. | 10. IF UNDER 1 YEAR Months 78 Days 0 Hours 0 Min. | | 11. IF UNDER 24 HRS Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-ret. | | 10b. KIND OF BUSINESS OR INDUSTRY Austria | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Leopold John | | 14. MOTHER'S MAIDEN NAME Don't know | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 213-07-3512 | |
| 17. INFORMANT Roland W. John | | Address 1906 Jefferson Road-22 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422-1 DUE TO Arteriosclerotic Cardiovascular Disease - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 1959 to Oct 30, 1960 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1959 to Oct 30 , 19 60 that (I) (we) last saw the deceased alive on Oct 30 , 19 60 and that death occurred 12 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John E. Gessner | | 22b. DATE 10-31-60 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN E. GESSNER | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/2/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City, town, or county) (State) Colgate, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md. | | 25a. REC'D BY REGISTRAR DATE NOV 3 '60 | |
| 25b. REGISTRAR'S SIGNATURE Cuthbert S. Hanna | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

111111

11091

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 62 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY / c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (14) d. STREET ADDRESS 2617 Canterbury Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CIARENCE Middle F. Last JOHNSON | | 4. DATE OF DEATH Month October Day 12 Year 1960 | |
| 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 16, 1892 9. AGE (In years last birthday) yrs. 68 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Captain- 13. FATHER'S NAME William J. Johnson | | 10b. KIND OF BUSINESS OR INDUSTRY Tugboat 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. WW I 212-07-7709 | | 17. INFORMANT Clinical Records, VAH, Baltimore 18, Md. Address FT. HOWARD DIVISION | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162-1 DUE TO PULMONARY EDEMA CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO BRONCHOGENIC CARCINOMA, LEFT LUNG AND ARTERIOSCLEROTIC HEART DISEASE (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN UNKNOWN | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BENIGN PROSTATIC HYPERTROPHY | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from August 11, 1960 , to October 12, 1960 , that (I) (we) last saw the deceased alive on October 12, 1960 , and that death occurred at A. M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Frederick S. Donaldson M.D. 22c. PHYSICIAN'S NAME (Type) FREDERICKS, DONALDSON, M.D. | | 22b. DATE 10/12/60 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-15-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Funeral Home | | 25a. REC'D BY REGISTRAR Baltimore 14, Md. 25b. REGISTRAR'S SIGNATURE Oct 13 '60 | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or for a burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11092
Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> <u>HOLY BEACH RD.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u> c. LENGTH OF STAY IN 1b <u>12 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY BEECH RD.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOLY BEACH RD.</u> d. STREET ADDRESS <u>MIDDLE RIVER</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>K.</u> Last <u>JUNUSKA</u> | | 4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>20</u> Year <u>1960</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR. 29 1884</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>15</u> Min. <u>00</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>COAT-MAKER</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles JUNUSKA</u> | | 14. MOTHER'S MAIDEN NAME <u>?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>815-09-7590A</u> | |
| 17. INFORMANT <u>Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart dis</u> (c) <u>1 yr.</u> DUE TO (a) stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>p. m.</u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Jack C Collins</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JACK C COLLINS</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>OCT 25 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>WEST HOLY REDEEMER</u> | | 22d. LOCATION (City, town, or county) (State) <u>BE LAIR RD MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W Lachowich</u> | | ADDRESS <u>637 Washington</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE OCT 26 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

10-23-60



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1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11093

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|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Green Spring Manor apt 201</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt MD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Torleigh Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Karl</u> Middle <u>Kahn</u> Last <u>Kahn</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>8</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 28 1897</u> |
| 9. AGE (In years lost birth day) <u>63</u> yrs. | IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u></u> Min <u></u> | IF UNDER 24 HRS Hours <u></u> Min <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Finance</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Charles Town W Va</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U S</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S</u> | |
| 13. FATHER'S NAME <u>William Kahn</u> | | 14. MOTHER'S MAIDEN NAME <u>Jda Weil</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-05-3751</u> | |
| 17. INFORMANT <u>Mrs Alice b Kahn</u> Address <u>Green Spring Manor apt 201</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Vascular Accident (left) - with at</u> DUE TO <u>hypertensive C.V. & arterial sclerosis.</u> (b) <u>Coronary artery Disease.</u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 27 1960</u> to <u>Oct 8 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 8 1960</u> , and that death occurred at <u>5 M</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Bernard J. Cohen</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>DR. BERNARD J. COHEN</u> | | 22d. ADDRESS <u>The Marylander apt. 3501 St. Paul</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>10/10/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ches. Shalom B'nai</u> | 23d. LOCATION (City, town, or county) (State) <u>6100 O'Donnell St MD</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Dan R Martin</u> | | 25a. REC'D BY REGISTRAR <u>OCT 17 '60</u> | |
| ADDRESS <u>1902 Eutaw place</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |
| | | <u>Balt MD</u> | |





FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

VS. A15ME
SM 7/59

11111 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11095

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| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4218 Soth Avenue</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> d. STREET ADDRESS <u>4218 Soth Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) <u>LOUISE C. KEETON</u> | | 4. DATE OF DEATH <u>October 9, 1960</u> | |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 10, 1906</u> 9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours M'n. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u> 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Malcolm Carter</u> | | 14. MOTHER'S MAIDEN NAME <u>Virgie Irby</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Mr. Ernest L. Keeton</u> 17. INFORMANT <u>4218 Soth Ave. 6</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>Arteriosclerotic cardiovascular disease</u> <u>Carcinoma of right ovary with abdominal metastases;</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingested tuinal</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. ? 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown</u> 20f. (City or town) <u>Unknown</u> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u> | | DATE SIGNED <u>10/17/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-13-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u> | | 22d. LOCATION (City, town, or country) <u>Richmond, Virginia</u> (State) | |
| 23. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u> | | 24a. REC'D BY REGISTRAR <u>OCT 20 60</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

2

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Film #293 - 10/20/60 - Two for one certificate -
Medial certification changed - *W.B.*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

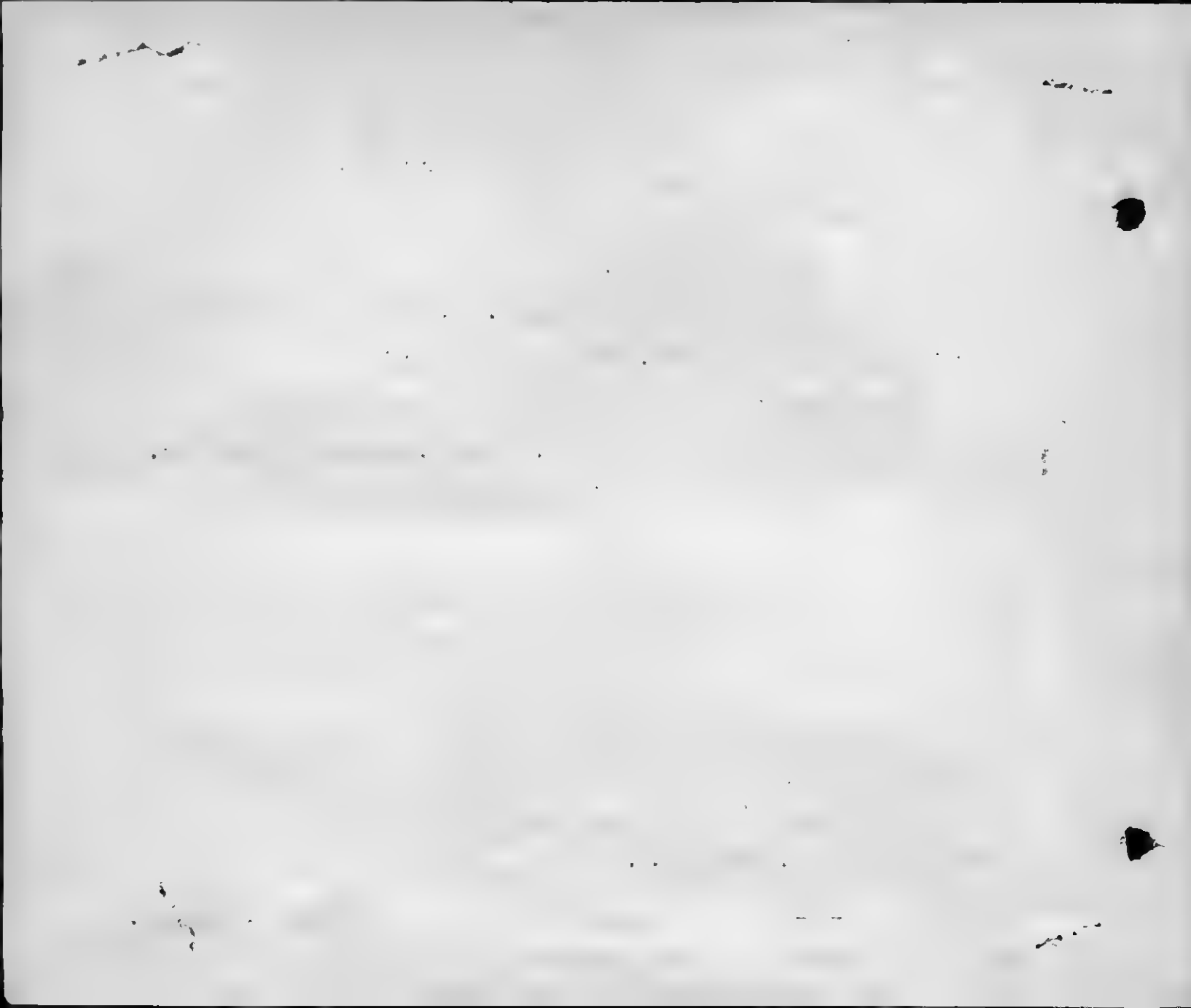
VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | |
| c. LENGTH OF STAY IN 1b <u>4218 Soth Avenue</u> | | d. STREET ADDRESS <u>4218 Soth Avenue</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4218 Soth Avenue</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>LOUISE C. KEETON</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>19 60</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 10, 1906</u> | |
| 9. AGE (in years last birthday) <u>54</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Malcolm Carter</u> | | 14. MOTHER'S MAIDEN NAME <u>Virgie Trby</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Mr. Ernest L. Keeton 4218 Soth Ave. 6</u> | |
| 17. INFORMANT <u>Mr. Ernest L. Keeton 4218 Soth Ave. 6</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease complicating</u> <u>carcinoma of right ovary with abdominal metastases</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. _____ | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>PARTIAL</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ | | 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PARTIAL</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Russell S. Fisher</u> | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>10/10/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-13-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u> | | 22d. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u> | |
| 23. FUNERAL DIRECTOR <u>Lecahn Funeral Home</u> | | 24a. REC'D BY REGISTRAR <u>OCT 13 '60</u> | |
| ADDRESS <u>7401 Delair Rd.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneass</u> | |



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

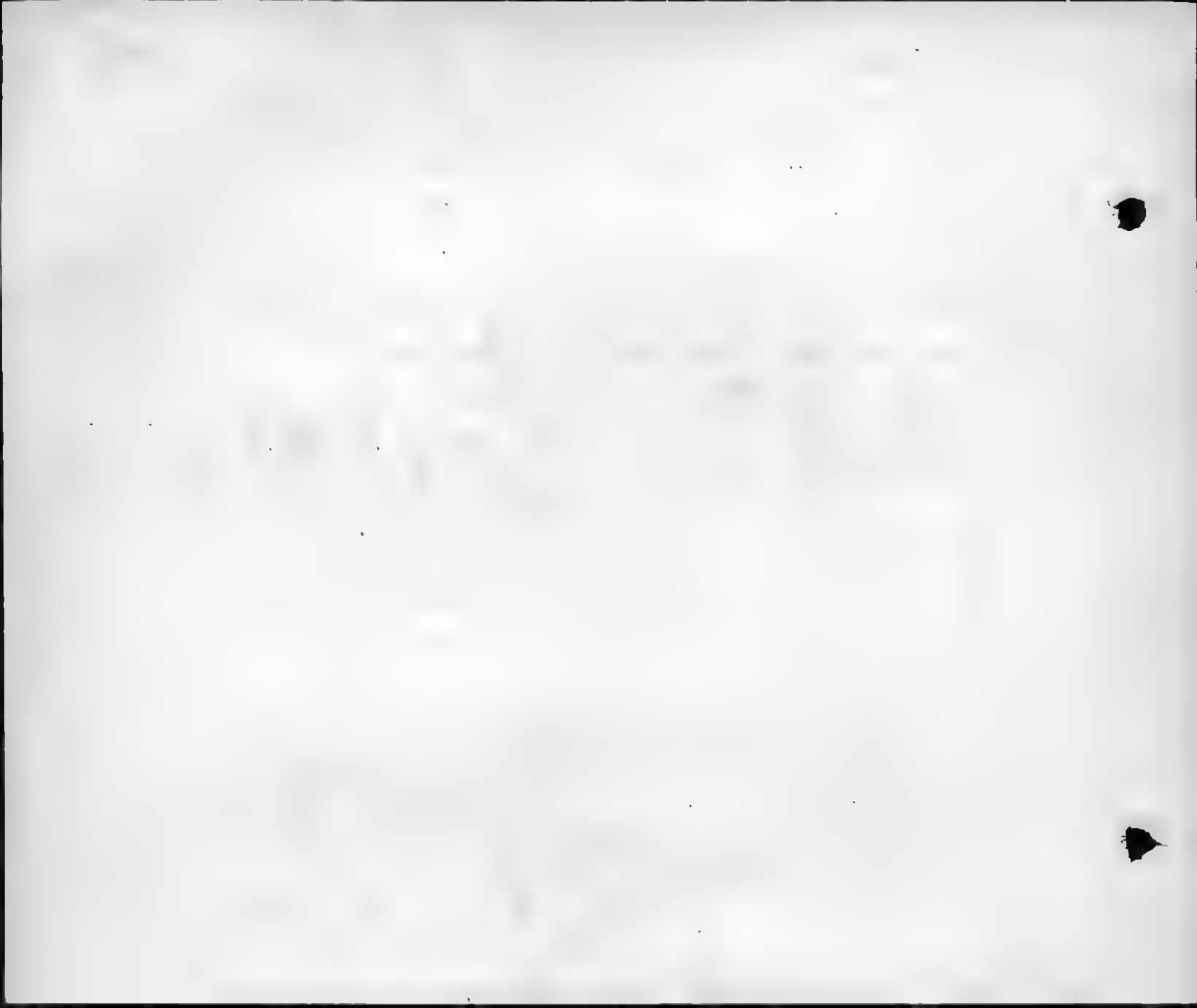
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11116

11096

| | | | | | | | |
|--|-------------------------------|--|----------------------------------|--|--|--|----------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>1 month</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | d. STREET ADDRESS <u>1349 James St.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>M</u> Last <u>Keyser</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/6/1892</u> | | 9. AGE (in years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Walter</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Greening</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Mr Henry A. Keyser</u> Address <u>Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Age</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 14, 1960</u> to <u>Oct 22, 1960</u> that (I) (we) last saw the deceased alive on <u>Oct 12, 1960</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Cliff Ratliff, Sr.</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <u>10/22/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, SR.</u> | | | | 22d. ADDRESS <u>4605 Edmondson Ave #29</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/25/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Edmondson & Longwood Sts.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> ADDRESS <u>1001 Hollins St.</u> | | | | 25a. REC'D BY REGISTRAR <u>Oct 24 60</u> DATE | | 25b. REGISTRAR'S SIGNATURE <u>Cliff Ratliff</u> | |



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, and in any event within 72 hours after death.
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

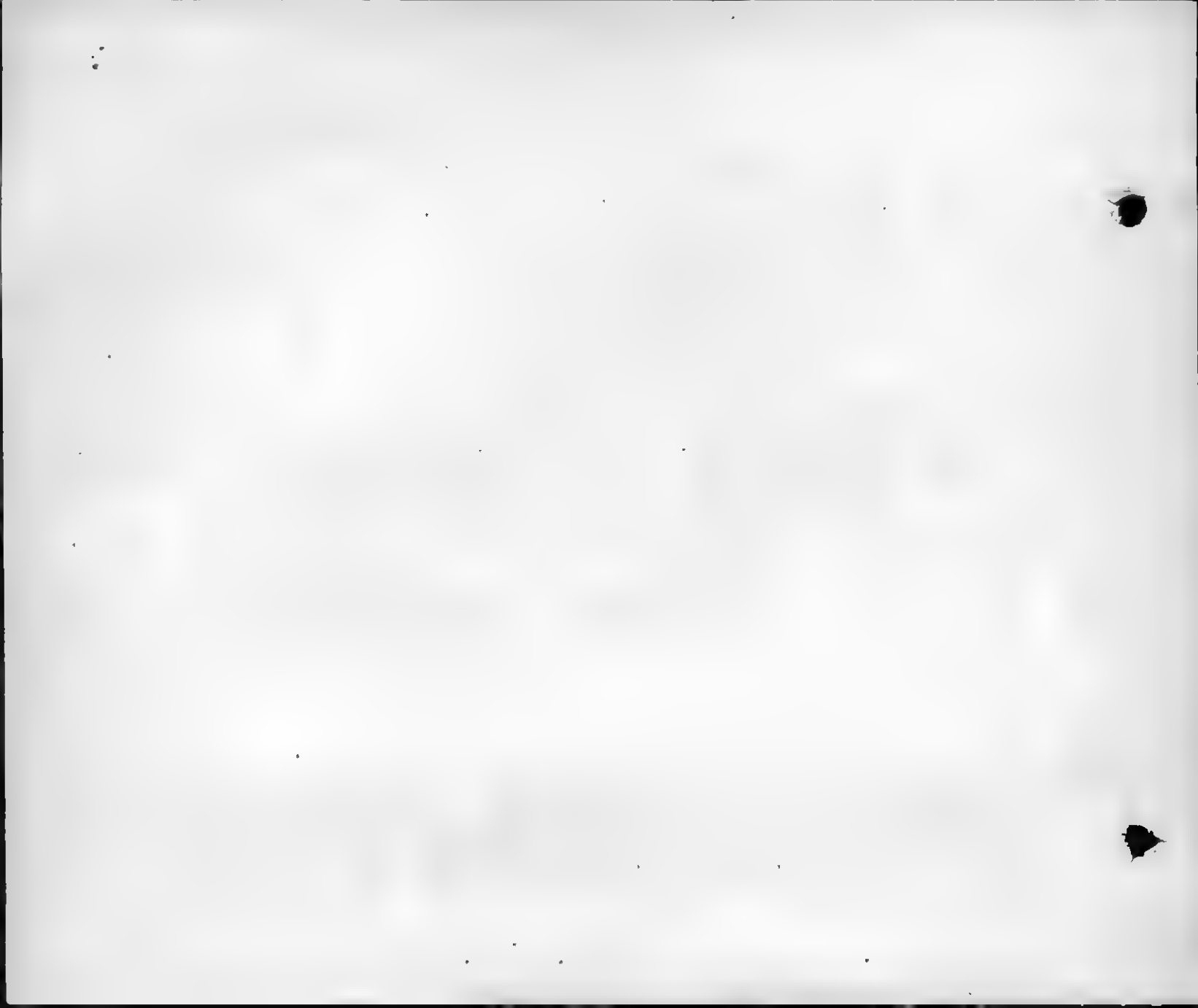
VR A15 (4)
15M 9/59

111117

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11097

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland | | | | c. LENGTH OF STAY IN 1b 18 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| f. STREET ADDRESS 2011 N. Payson Street | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First SETH Middle --- Last KING | | | | 4. DATE OF DEATH Month October Day 28 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 9, 1891 | |
| 9. AGE (In years last birthday) 69 yrs. | | 10. IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min. | | 11. IF UNDER 24 HRS Months 28 Days 28 Hours 28 Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | | |
| 11. BIRTHPLACE (State or foreign country) King William, Virginia | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME John King | | | | 14. MOTHER'S MAIDEN NAME Kate Page | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I | | | | 16. SOCIAL SECURITY NO Clin. Rec. VAH Baltimore, Md. Fort Howard Div. | | | |
| 17. INFORMANT Clin. Rec. VAH Baltimore, Md. Fort Howard Div. | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE WITH WIDESPREAD METASTASES DUE TO (b) 20 mos. DUE TO (c) 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH 20 mos. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 10, 1960 to Oct. 28, 1960 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Oct. 28, 1960 , and that death occurred at P. M. from the causes and on the date stated above | | | | 22a. SIGNATURE NORMAN P. JONES, M.D. | | | |
| 22b. DATE SIGNED 10/28/60 | | | | 22c. PHYSICIAN'S NAME (Type) NORMAN P. JONES, M.D. | | | |
| 22d. ADDRESS VAH, Fort Howard, Maryland | | | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 11/1/60 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips | | | | 25a. REC'D BY REGISTRAR 1808-10 N. M. Monroe Balto. 17, Md. | | | |
| 25b. REGISTRAR'S SIGNATURE Charles L. Yarnall | | | | 25c. DATE NOV 1 '60 | | | |



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

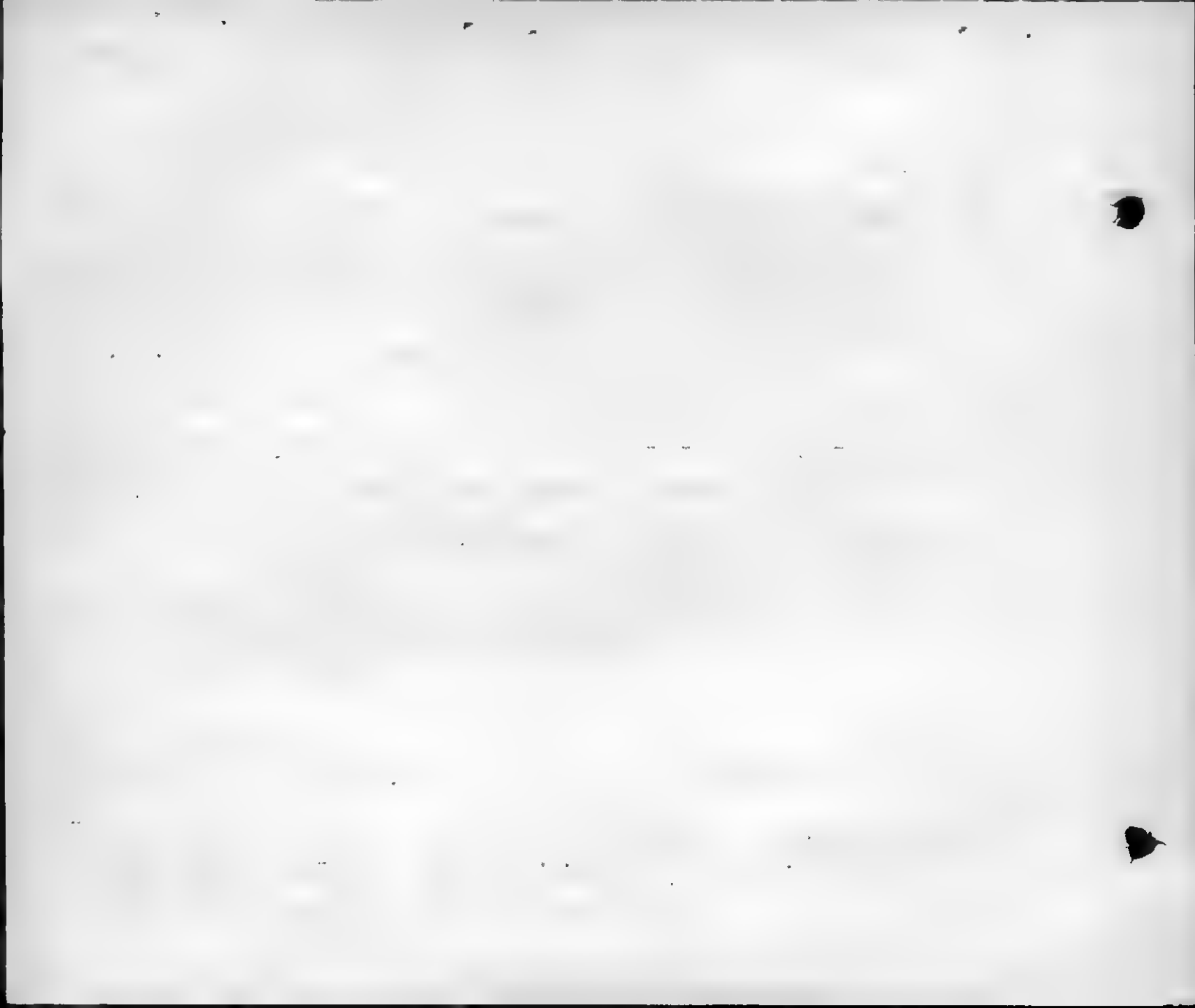
CERTIFICATE OF DEATH

11098

Item 6 Film 9274 10-31-60 et

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| c. LENGTH OF STAY IN lb 3 DAYS | | d. STREET ADDRESS 1960 EDMERE AVENUE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF KIRBY (Type or print) First Middle Last | | 4. DATE OF DEATH Month Day Year October 22 1960 | |
| 5. SEX MALE | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 20 1906 |
| 9. AGE (In years lost birthday) 54 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ROBERT KIRBY | | 14. MOTHER'S MAIDEN NAME CATHERINE THOMPSON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WW-11 213-10-2712 | |
| 17. INFORMANT CLIN REC VAH BALTO 18 MD-Ft HOWARD DIVISION | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RUPTURE OF THE ESOPHAGUS DUE TO (c) UNKNOWN | | INTERVAL BETWEEN ONSET AND DEATH 26 HOURS | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL HEMORRHAGE - 4 DAYS | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XX (this hospital) attended the deceased from October 19, 1960 to October 22, 1960 that (X) (we) last saw the deceased alive on October 22, 1960 , and that death occurred at 4:35 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles E. Rowan | | 22b. DATE SIGNED 10-22-60 | |
| 22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN | | 22d. ADDRESS M.D. VAH BALTO 18 MD - FT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-25-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEMORIAL GARDENS | | 23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost | | 25a. REC'D BY REGISTRAR OCT 24 '60 | |
| 25b. REGISTRAR'S SIGNATURE Ellsworth Armacost | | 25c. REGISTRAR'S SIGNATURE Ellsworth Armacost | |

Liberty Heights Ave Baltimore Maryland



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. This page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

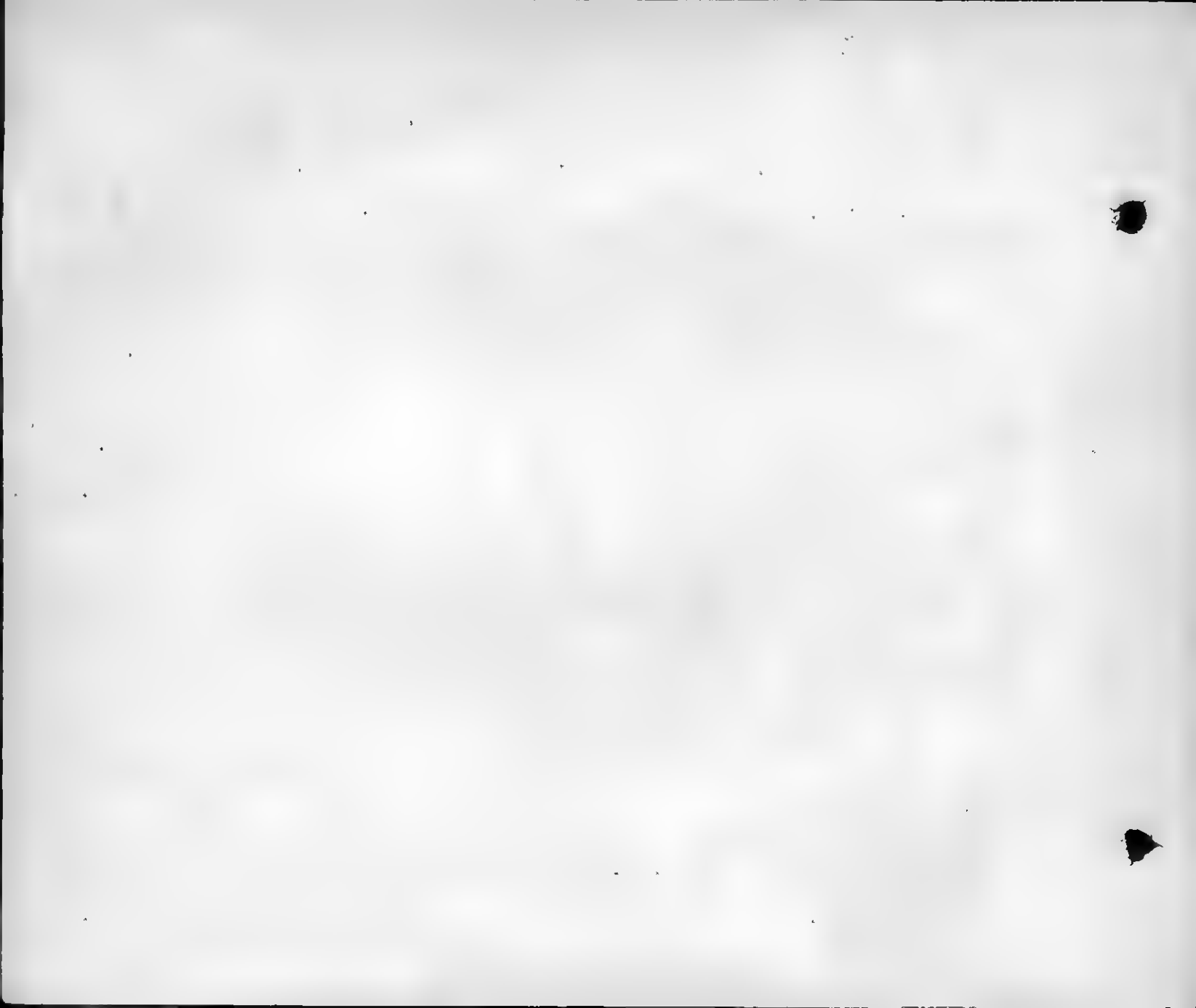
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

111119

11099

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u> | | c. LENGTH OF STAY IN 1b <u>10 yrs.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u> X | | d. STREET ADDRESS <u>Kenmar Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kenmar Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Stewart</u> Last <u>Knott</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 29, 1892</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | |
| 11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>woodshopper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Woodholm Club</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Henry Knott</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Jane Short</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>214-20-0269</u> | |
| 17. INFORMANT <u>Mrs. Rose Hoff, 201</u> | | Address <u>11099</u> , <u>Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. est.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>none</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>none</u> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u> | | 20f. (City or town) (County) (State) <u>none</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>D.D. Caples</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>10-24-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 25, 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Newell, Pikesville, Md.</u> | | 24. REC'D BY REGISTRAR <u>DATE OCT 26 '60</u> | |
| ADDRESS <u>Pikesville, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11120

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 11 Film 6213 10-20-60 et
CERTIFICATE OF DEATH

11100

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admiss on) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>30114</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME.</u> | | d. STREET ADDRESS <u>6801 Duluth Avenue</u> <u>329 HARLEM AVE.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>M</u> Last <u>KOPONEC</u> | | 4. DATE OF DEATH Month <u>10</u> - Day <u>8</u> Year <u>1960</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Boat-Steel</u> | 11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>I</u> | |
| 14. MOTHER'S MAIDEN NAME <u>!</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | |
| 16. SOCIAL SECURITY NO. <u>216-10-1182</u> | | 17. INFORMANT Address <u>Mrs Thomas Dobishy 1801 Duluth Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis generalized</u> DUE TO (c) <u>unknown</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Age</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>59</u> , to <u>10/8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/3</u> , 19 <u>60</u> , and that death occurred at <u>4 45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 EDMONDSON AVE.</u> DATE SIGNED <u>CLIFF RATLIEF, JR.</u> | | | |
| ACTUAL SIGNATURE <u>Cliff Ratlief, Jr.</u> M.D. | | PHYSICIAN'S NAME (Type) <u>CLIFF RATLIEF, JR.</u> <u>BALTIMORE 29, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>10-11-60</u> | <u>Sacred Heart of Mary</u> | <u>Baltimore Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Dabrowski 1001 Dundell Ave.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 14 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> |

6801 41 1/2 0.2
1 1/2.

2-131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

11121

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11101

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 10 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| f. STREET ADDRESS 3109 D'Donnell Street | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MICHAEL Middle - Last KOTCH | | 4. DATE OF DEATH Month OCTOBER Day 9 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/31/96 |
| 9. AGE (In years last birthday) 63 yrs. | 10. IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min 63 | 11. IF UNDER 24 HRS Months 63 Days 63 Hours 63 Min 63 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Riviter | | 10b. KIND OF BUSINESS OR INDUSTRY Steel | |
| 11. BIRTHPLACE (State or foreign country) Freeland, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Kotch | | 14. MOTHER'S MAIDEN NAME Anna Greshke | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 217-09-9470 | |
| 17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMATOSIS PROBABLE LUNG DUE TO (c) TUBERCULOSIS PULMONARY FAR ADVANCED | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOCYTOPENIA PURPURA | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from Sept. 29 , 1960, to Oct. 9 , 1960, that (X) (we) last saw the deceased alive on October 9 1960 , and that death occurred on 1:20 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas R. Hood | | 22b. DATE SIGNED 10/9/60 | |
| 22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D. | | 22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 10-13-60 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. | | 25a. REC'D BY REGISTRAR ACT 11 '60 | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline |

2

MEDICAL CERTIFICATION

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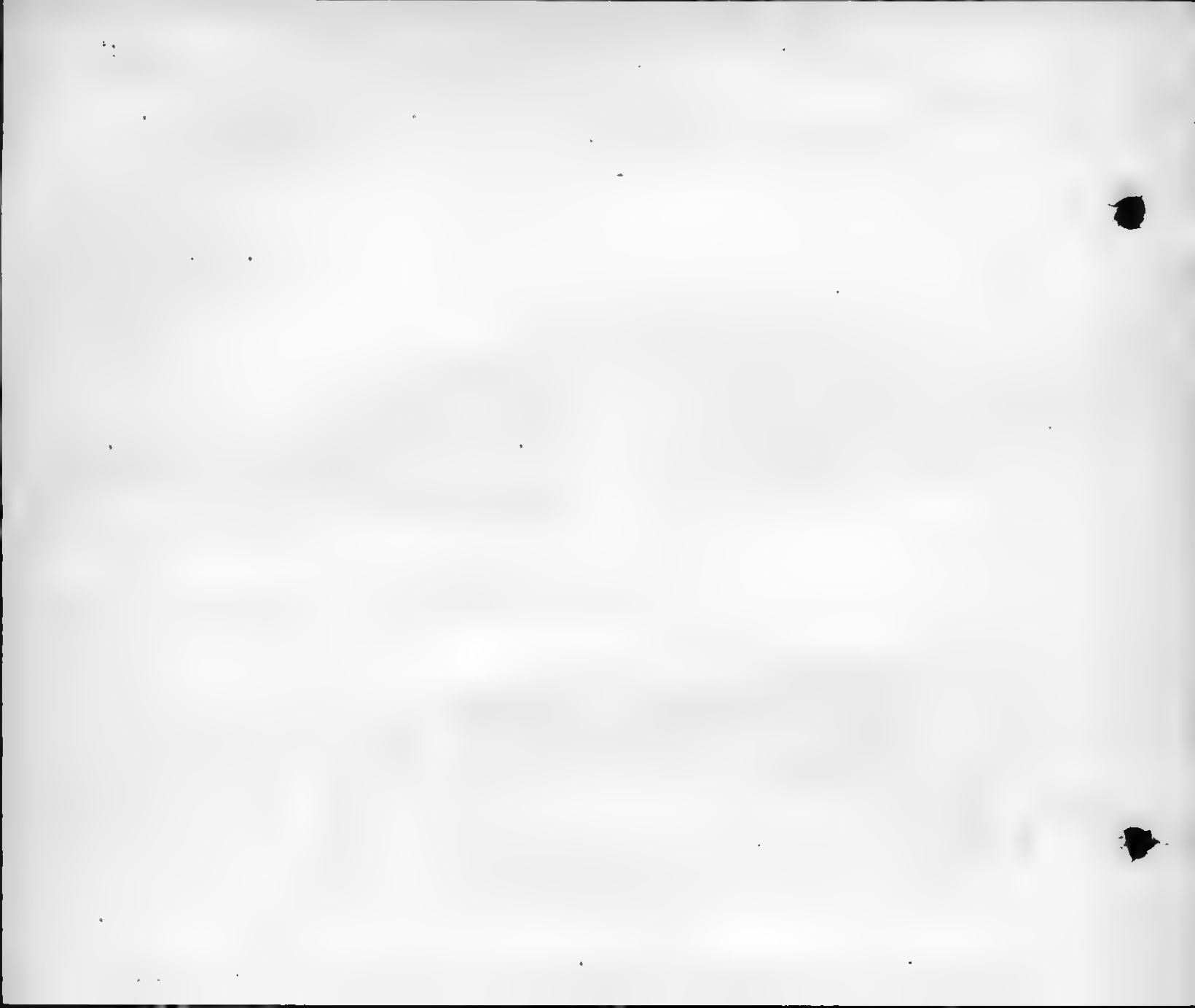
1 3 M X 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

11043

CERTIFICATE OF DEATH

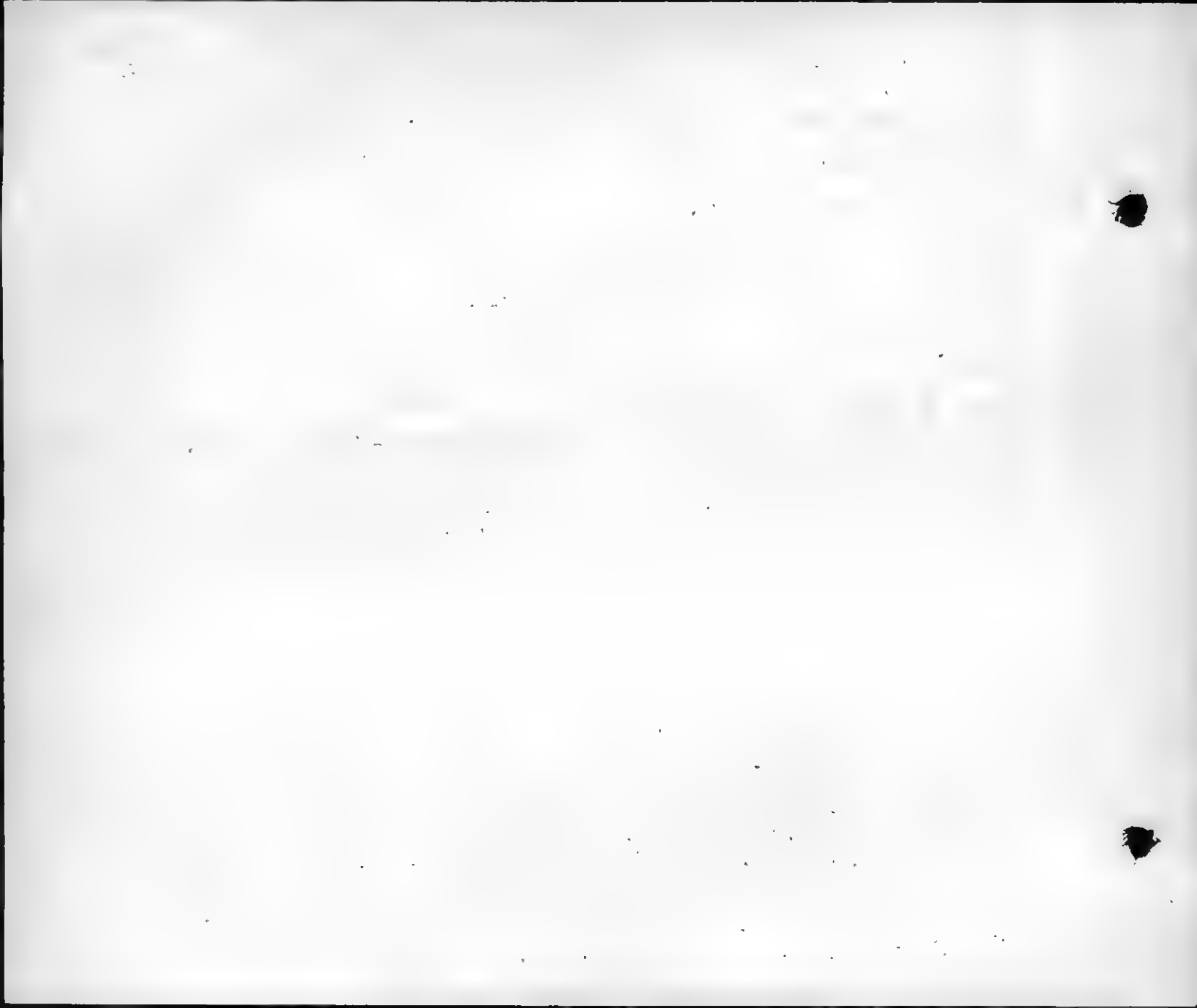
Reg. Dist. No. 11102

| | | | |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | c. LENGTH OF STAY IN 1b 12 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Old Hanover Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Louise Middle Kreamer Last Kreamer | | 4. DATE OF DEATH Month Oct. Day 11 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 29, 1878 |
| 9. AGE (In years last birthday) yrs 82 | | IF UNDER 1 YEAR: Months 11 Days 19 Hours 19 Min 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Box Maker | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Peter Kreamer | | 14. MOTHER'S MAIDEN NAME Louise Snyder | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT Miss. Barbara Kreamer | | Address Reisterstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 1 week years | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 7, 1960 , to Oct 11, 1960 , that I lost saw the deceased olive on Oct 10, 1960 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Charles E. McWilliams M.D. 11904 Reisterstown Rd Reisterstown, Md | | DATE SIGNED Oct 11, 1960 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/14/60 | 22c. NAME OF CEMETERY OR CREMATORY Western Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE George A. Nusbaum | | ADDRESS Reisterstown, Md. | |
| 24a. REC'D BY REGISTRAR DATE OCT 13 '60 | | 24b. REGISTRAR'S SIGNATURE 11102 | |



11103
Reg. Dist. No.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|-------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE | | Md. | | b. COUNTY | | Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Rural - Rosedale | | c. LENGTH OF STAY IN 1b | | unknown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Belair | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 1607 Odell Ave. | | d. STREET ADDRESS | | RT #2 - Box 136 | | 121- | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | 4. DATE OF DEATH | | Month | | Day | |
| Annie | | | | | | Krumel | | October | | 20 | | 19 60 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 4-6-1876 | | 84 yrs. | | Months | | Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| Housewife | | | | Czechoslovakia | | USA | | | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| John Kriss | | Unknown | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | INFORMANT | | Address | | | | | | | |
| No | | none | | Anton C. Kriss - 1607 Odell Ave. (6) | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 422.1 | | DUE TO | | Pulmonary Edema | | INTERVAL BETWEEN ONSET AND DEATH | | 3 wks | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO | | (c) | | Arteriosclerotic C.V. Disease | | 12 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from Oct 7, 1948, to Oct 2, 1960, that I last saw the deceased alive on Oct 2, 1960, and that death occurred at 2 A. M., from the causes and on the date stated above | | ADDRESS (Street, city or town, state) | | DATE SIGNED | | | | | | | | | |
| ACTUAL SIGNATURE | | J. Ralph Horky | | M.D. | | 10/21/60 | | | | | | | |
| PHYSICIAN'S NAME (Type) | | J. Ralph Horky | | Churchville, Md. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) | | (State) | | | | | |
| Burial | | 10-22-60 | | Holy Redeemer Cemetery | | Baltimore, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE | | | | | | | |
| J. I. L. L. L. | | 1211 Chesaco Ave. | | OCT 25 '60 | | C. L. L. L. | | | | | | | |

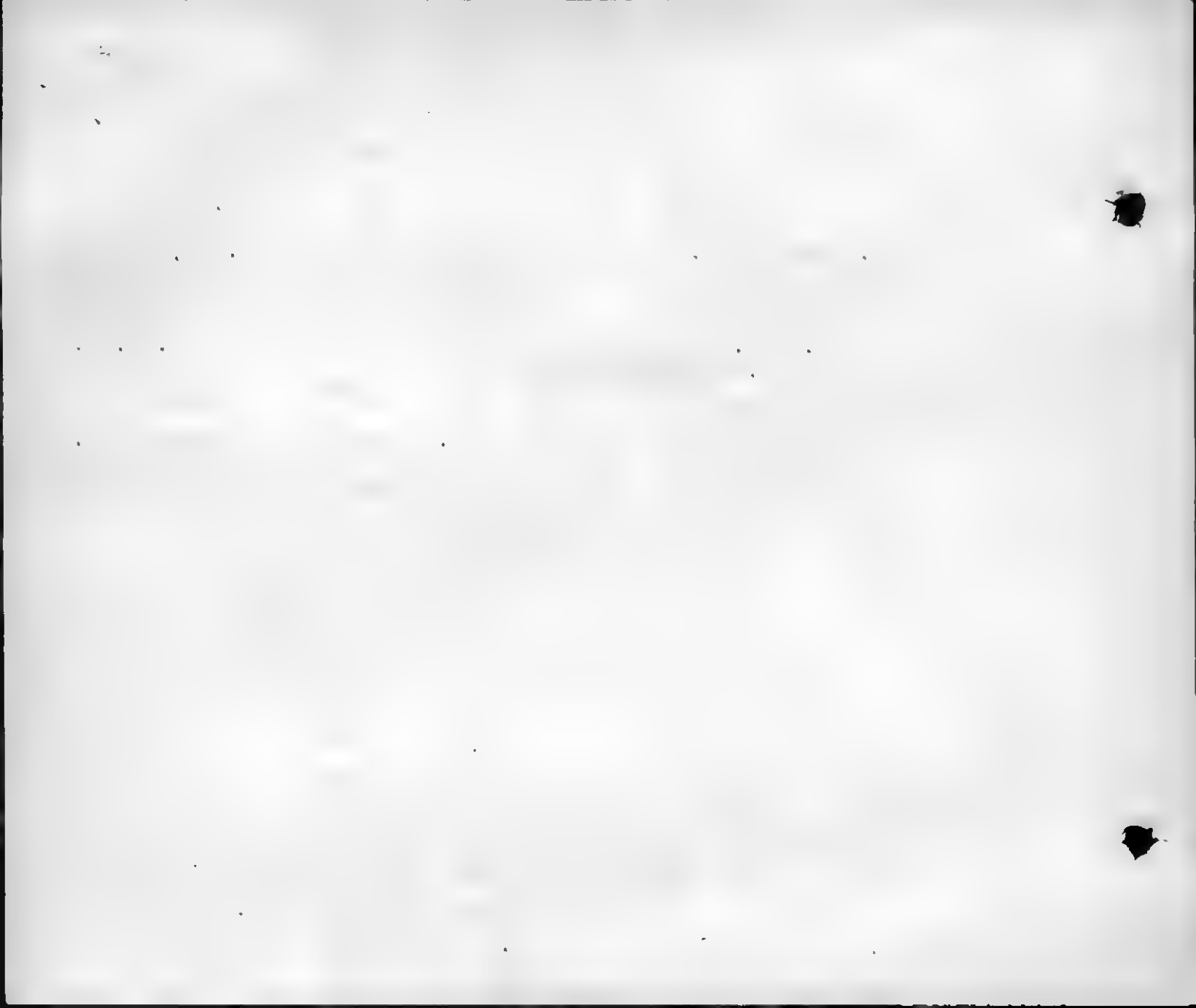


11125

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11104

| | | | |
|--|-----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home | | d. STREET ADDRESS 2929 Guilford Ave. #18 | |
| 3. NAME OF DECEASED (Type or print) Dr. Constant J. Kryzanowsky | | 4. DATE OF DEATH Oct. 21, 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 8, 1881 |
| 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor of Mech. Eng. & Physicist | | 10b. KIND OF BUSINESS OR INDUSTRY Russia | |
| 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Constant J. Kryzanowsky | | 14. MOTHER'S MAIDEN NAME Martha Feldt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 218-18-8893 | |
| 17. INFORMANT Mattie L. Furness | | Address 2929 Guilford Ave. #18 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1 + 43X IMMEDIATE CAUSE (a) Multiple Cerebral Vascular Accidents. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular (c) Dissecting | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 15 Sept 1960 to 21 Oct 1960 that (I) (we) last saw the deceased alive on 10/20/60 and that death occurred 1225 PM from the causes and on the date stated above. | | 22a. SIGNATURE [Signature] M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) W. E. McGrath MD | | 22d. ADDRESS 1303 Frederick Rd Catonsville 28 Md | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 10/22/60 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory Baltimore, Maryland | |
| 23d. LOCATION (City, town, or county) (State) | | 24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave. | |
| 25a. REC'D BY REGISTRAR OCT 24 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Frank | |



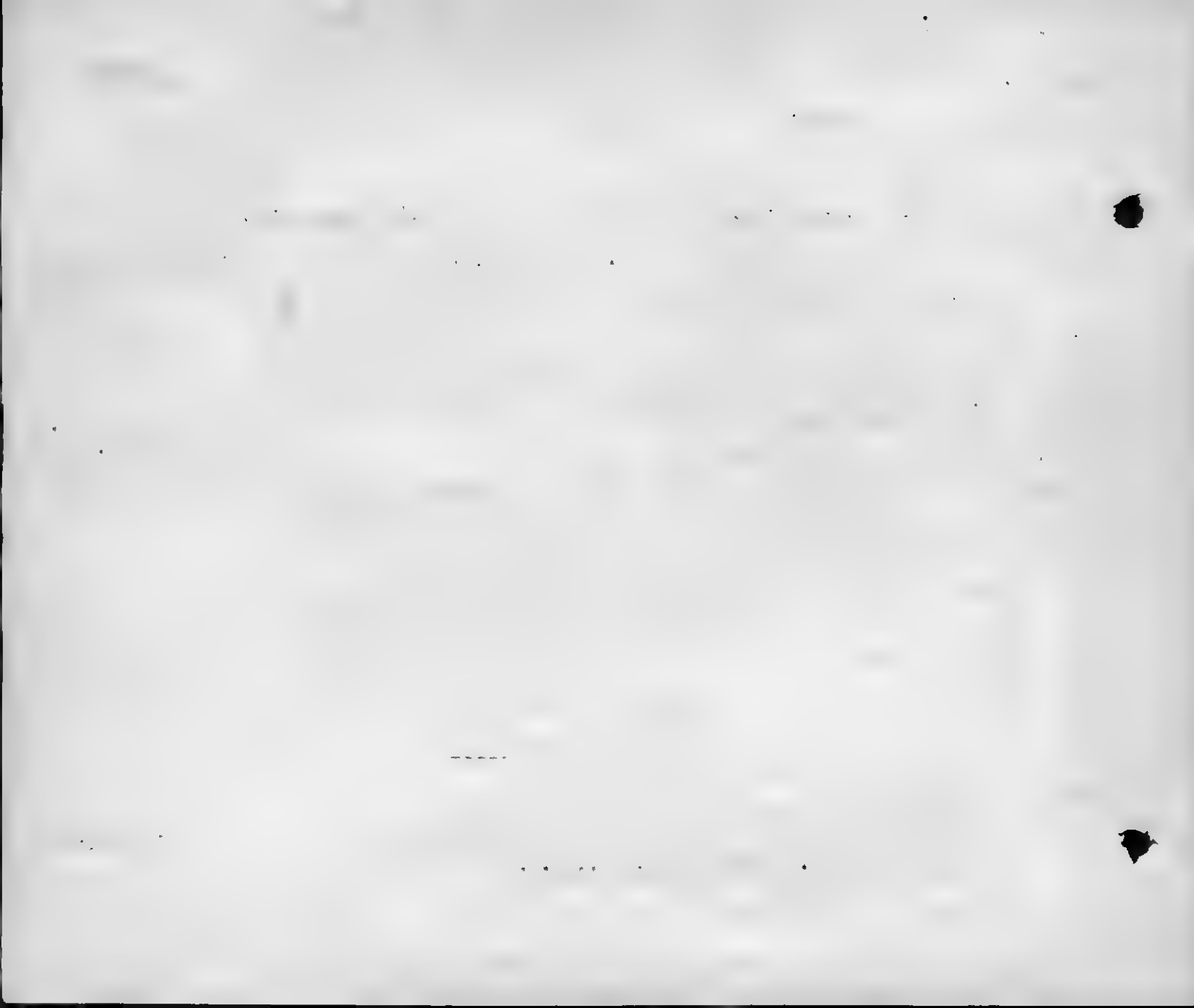
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 11124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Items 10, 11, 12 Film 73-10-20-60 et 11105 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34 | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9912 Finney Drive | | | | | e. STREET ADDRESS 9912 Finney Drive | | | | |
| 3. NAME OF DECEASED (Type or print) DAVID M. KURTZ | | | | | 4. DATE OF DEATH October 12 1960 | | | | |
| 5. SEX Male | | | | | 6. COLOR OR RACE White | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH 3-3-1898 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | | 9. AGE (In years last birthday) 62 yrs | | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Shippensburg, Penna. | | | | |
| 13. FATHER'S NAME Samuel B Kurtz | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | | | 14. MOTHER'S MAIDEN NAME Agnes Smith | | | | |
| 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Van Seyoc Funeral Home - 112 W. King St. / Shippensburg, Pa. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.0 DUE TO Arteriosclerotic heart disease (c) 420.0 DUE TO Arteriosclerotic heart disease | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year 19 | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE W. Bradley King, Jr., M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| DATE SIGNED 10/13/60 | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 10/13/60 | | | | | 22b. DATE THEREOF 10/13/60 | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Spring Hill | | | | | 22d. LOCATION (City, town, or country) (State) Shippensburg, PA | | | | |
| 23. FUNERAL DIRECTOR W. J. Tickner & Sons, Balto. Md | | | | | 24a. REC'D BY REGISTRAR OCT 14 '60 | | | | |
| ADDRESS W. J. Tickner & Sons, Balto. Md | | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | | |

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11125

11106
Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|--|--------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOUVANS</u> | | c. LENGTH OF STAY IN 1b <u>25 YRS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOUVANS</u> | | d. STREET ADDRESS <u>6326 SMITH CT. 1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6326 SMITH CT.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET (MARGUERITE) LANDERS</u> | | | | 4. DATE OF DEATH Month Day Year <u>10/24/60 19</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 4, 1899</u> | 9. AGE (In years last birthday) <u>61</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILIES</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>ISAAC THOMAS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ROSE COLE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>21720-9258</u> | | 17. INFORMANT Address <u>JESSE LANDER-6326 SMITH CT.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4-25-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>James F. C'Donnell</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>James F. C'Donnell</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/27/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u> | | 22d. LOCATION (City, town, or county) (State) <u>Towson, Balto. Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Whitman Jr.</u> | | | | 24a. REC'D BY REGISTRAR <u>27 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11126

11107
Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1yr. 4mth. 6dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 1011 Light Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Isaac Middle Mitchell Last Lawrence | | | | 4. DATE OF DEATH Month Oct Day 16 Year 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH May 28, 1877 | | 9. AGE (In years last birthday) 83 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Unknown) ret'd | | 10b. KIND OF BUSINESS OR INDUSTRY Boat Builder | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Peter Leslie Lawrence | | | | 14. MOTHER'S MAIDEN NAME Esther Anne Bozman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) un.own | | 16. SOCIAL SECURITY NO. 265-09-2482A | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Fracture of left femur | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell on 9-26-60 sustaining an intertrochanteric fracture of the left femur. | | | | | |
| 20c. TIME OF INJURY Hour 9:15 206 p. m. Month, Day, Year 9-26-60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | | 20f. (City or town) (County) (State) Catonsville 28, Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Geo. S. M. Kieffer M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Geo. S. M. Kieffer | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-19-60 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) 5829 Ritchie Highway, Zone 25 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR DATE OCT 19 60 | | 24b. REGISTRAR'S SIGNATURE Carlton S. Kraus | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No. 11108

11040

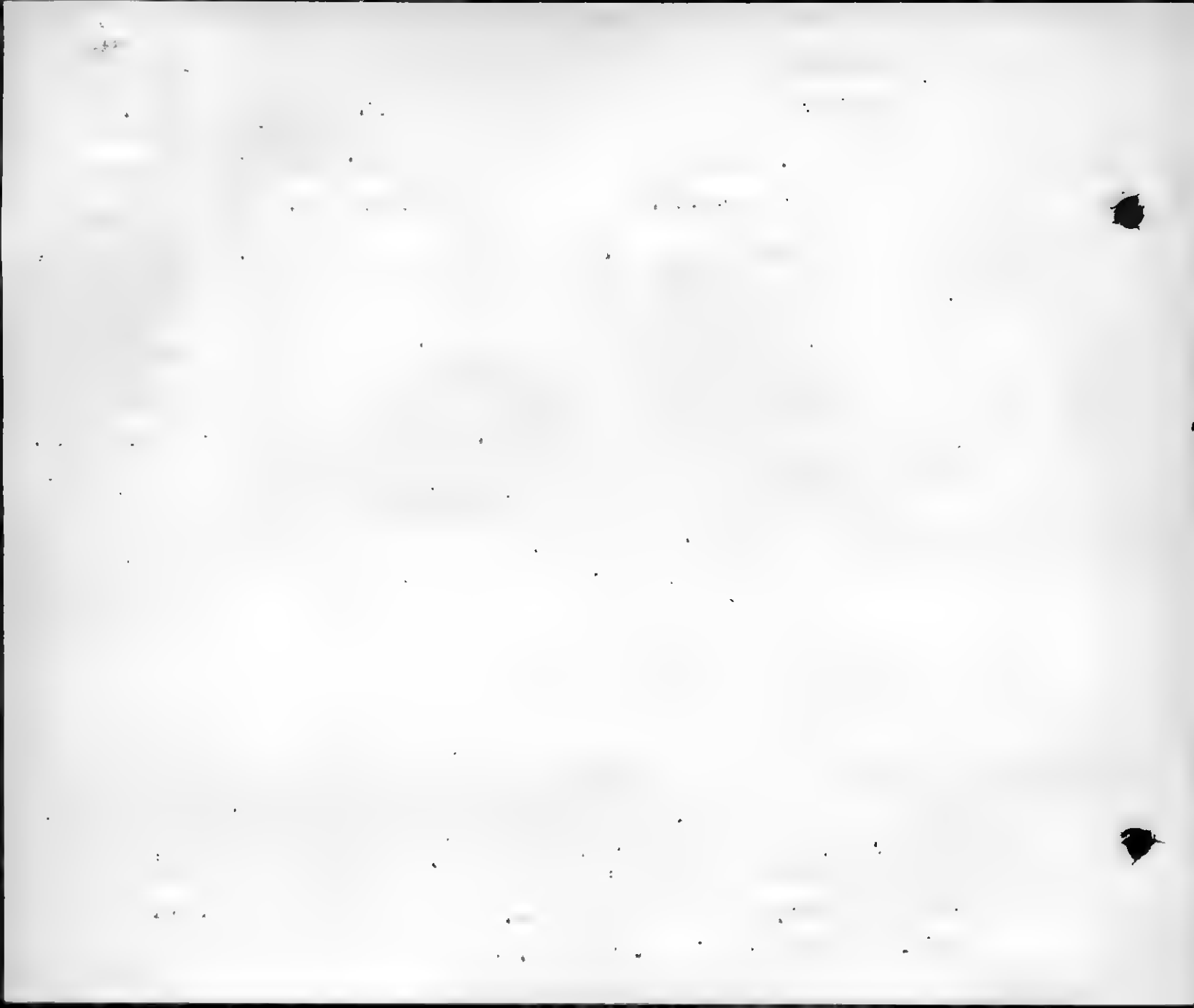
| | | | | | |
|--|---------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 Alabama Ave. | | | e. STREET ADDRESS 3000 Alabama Ave. | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle C. Last Lee | | | 4. DATE OF DEATH Month 10 Day 6 Year 19 60 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/2/82 | | 9. AGE (In years last birthday) 78 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME George Hopkins | | | 14. MOTHER'S MAIDEN NAME Elizabeth Bluford | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO | INFORMANT Address Mrs. Fredericks 3000 Alabama Ave. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Inter cerebral P. V D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Senile Dementia (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 10, 1960 to Oct 6, 1960 that I last saw the deceased alive on Oct 5, 1960 , and that death occurred at 9 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 301 Campbell Rd, 1076/60 DATE SIGNED ACTUAL SIGNATURE Paul Schmied M.D. PHYSICIAN'S NAME (Type) PAUL Schmied - Baltimore (30) Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/10/60 | | 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. | |
| 22d. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 10 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCully Funeral Homes 130 E. Fort Ave. # 30 | | | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11127

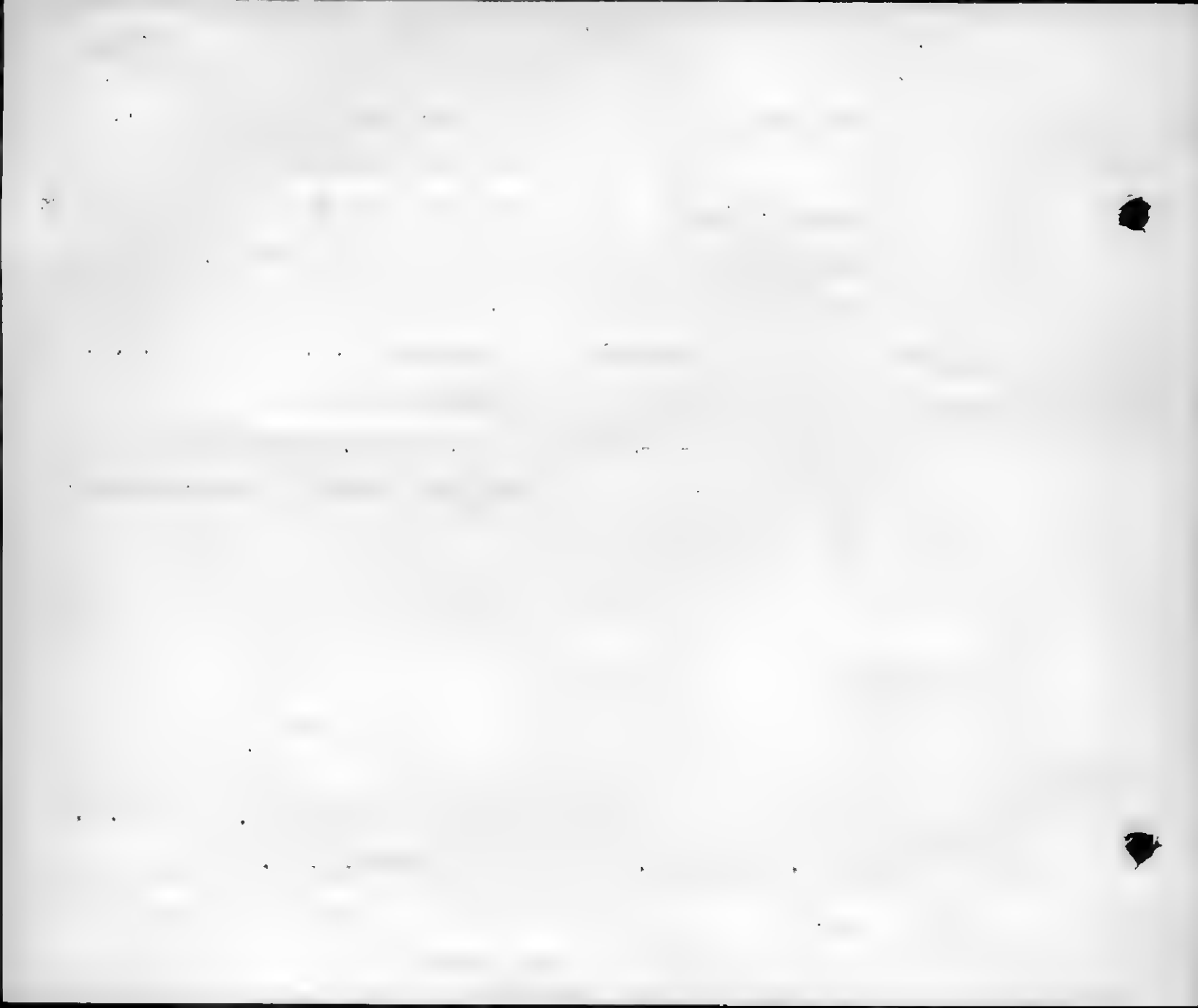
CERTIFICATE OF DEATH

Reg. Dist. No. 11109

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #20 Summerfield Road | | d. STREET ADDRESS #20 Summerfield Road | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle YORK Last LLOYD | | 4. DATE OF DEATH Month October Day 17 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 27, 1906 |
| 9. AGE (In years lost birthday) 54 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | 11. BIRTHPLACE (State or foreign country) Washington D.C. |
| 10b. KIND OF BUSINESS OR INDUSTRY Crown Oil | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Howard L. Lloyd | | 14. MOTHER'S MAIDEN NAME Sarah Simpson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 219-01-2675 | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) WWII | | INFORMANT Address Louise S. Lloyd #20 Summerfield Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Colon with metastases, generalized 153-18 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 months | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ***** | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. ***** p.m. 19 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ***** | 20f. (City or town) (County) (State) ***** |
| 21. I certify that I attended the deceased from 1950 to October , 1960, that I last saw the deceased alive on October 16 , 1960, and that death occurred at 1:00 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 5101 Gwynn Oak Ave. DATE SIGNED 10.18.60 | | | |
| ACTUAL SIGNATURE Millard T. Traband, Jr. M.D. | | DATE SIGNED 10.18.60 | |
| PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. | | Baltimore, 7, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct 19, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost | | 24a. REC'D BY REGISTRAR Oct 19 '60 | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines |
| ELLSWORTH ARMACOST 4600 Liberty Heights | | | |

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11128

11110

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>city</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>6 1/2 wks.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catons Ridge Nursing Home</u> | | | | d. STREET ADDRESS <u>901 McAleer Court</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lydia A. Ludloff</u> | | | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1960</u> | | | |
| 5. SEX <u>7</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/22/1880</u> | |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u> | | 11. BIRTHPLACE (State or foreign country) <u>md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Orlando Wilkinson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Patton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Martha W. Cofiell, 901 McAleer Court</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>age</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> 19 <u>60</u> , to <u>10/19</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>10/17</u> 19 <u>60</u> , and that death occurred at <u>4:40</u> P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Cliff Ratliff, Jr.</u> | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <u>10/19/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u> | | | | 22d. ADDRESS <u>4605 Edmond Ave #29</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-22-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u> </u> | | | |



111129
 MARYLAND STATE BOARD OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11111

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i> | | | | c. LENGTH OF STAY IN 1b <i>54</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>346 Savannah Ave</i> | | | | e. STREET ADDRESS <i>1346 Savannah Ave.</i> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>LOUISE</i> Middle <i>LUEBBEN</i> Last | | | | 4. DATE OF DEATH Month <i>Oct.</i> Day <i>10th</i> Year <i>1960</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Jan 22-1885</i> | 9. AGE (In years last birthday) <i>75</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>August Satter</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>7-10-100000</i> | | 17. INFORMANT <i>Betty Varuk - 9102 Lamage Ave.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO <i>Stroke</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>1 WEEK</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> to <i>10-10</i> , 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>10-10</i> , 19 <i>60</i> and that death occurred at <i>7:45 P.</i> M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>John E. Gessner</i> | | | | 22b. ADDRESS <i>JOHN' E. GESSNER</i> | | 22c. PHYSICIAN'S NAME (Type) <i>JOHN' E. GESSNER</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <i>Oct. 14-60</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cem.</i> | | 23d. LOCATION (City, town, or county) (State) <i>Balto, Co. Md</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Connolly</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>OCT 17 '60</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> | |

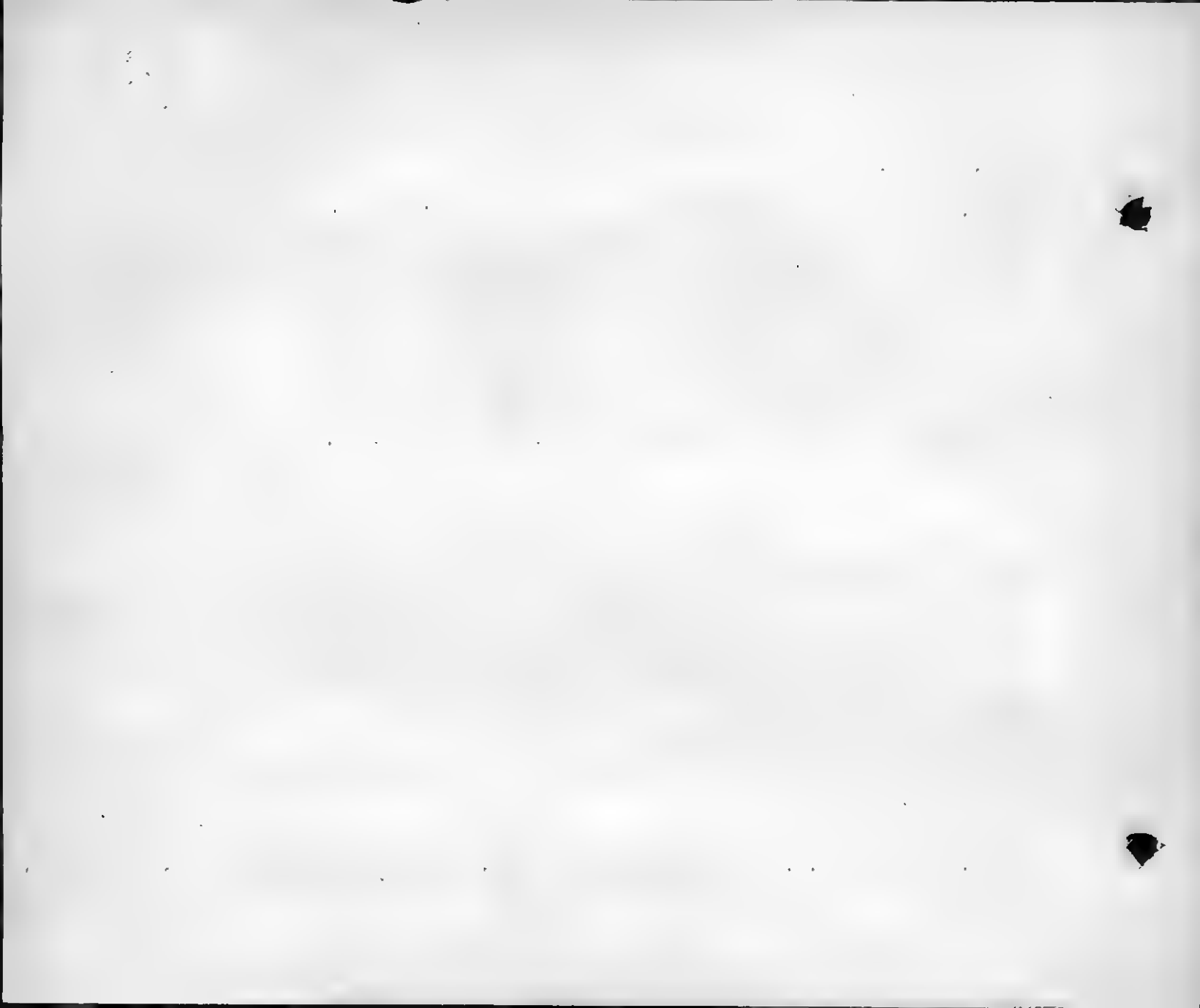


11130

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11112

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | | | c. LENGTH OF STAY IN 1b 5 1/2 MONTHS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| NAME OF DECEASED (Type or print) First CORA Middle B. Last MANOR | | | | 4. DATE OF DEATH Month 10 - Day 28 - Year 1960 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-1-73 | |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months 8 Days 28 Hours 12 Min. | | IF UNDER 24 HRS Hours 12 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME JACOB NAYLOR | | | | 14. MOTHER'S MAIDEN NAME ELIZA DRAKE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) ARTERIO SCLEROSIS DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-4-60 to 10-28-1960 , that (I) (we) last saw the deceased alive on 10-27-1960 , and that death occurred at 12:05 A.M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Wm. Newcomer M.D. | | | | 22b. DATE SIGNED 10-28-60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent | | | | 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10-31-60 | | 23c. NAME OF CEMETERY OR CREMATORY SAINT MARKS | | 23d. LOCATION (City, town, or county) (State) PETERSVILLE, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE B. McLeod ADDRESS BRUNSWICK, MARYLAND | | | | 25a. REC'D BY REGISTRAR NOV 2 '60 DATE | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
ATTENDING PHYSICIAN: The law requires that the attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| | | | |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b Joppa | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor | | d. STREET ADDRESS 12X-2 | |
| 3. NAME OF DECEASED (Type or print) First Esther Middle Saucer Last Masson | | 4. DATE OF DEATH Month October Day 28 Year 1960 | |
| 5. SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Nov. 7, 1905 |
| 9 AGE (In years last birthday) 54 yrs. | | 10a IF UNDER 1 YEAR Months 54 Days 10 Hours 28 Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY Georgia | |
| 11 BIRTHPLACE (State or foreign country) U. S. A. | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13 FATHER'S NAME ? Saucer | | 14 MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mr. Stevenson Masson | | Address Joppa, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: 443X DUE TO CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause as: HYPERTENSIVE CV DISEASE DUE TO 10 YRS. | | INTERVAL BETWEEN ONSET AND DEATH 22 HRS | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OSTEOARTHRITIS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from 7-28-1957 to OCT. 28 1960 , that (I) (was) last saw the deceased alive on OCT. 28 1960 , and that death occurred at 3:30 PM , from the causes and on the date stated above | | | |
| 22a SIGNATURE John F. Schaeffer | | 22b DATE SIGNED 10/29/60 | |
| 22c PHYSICIAN'S NAME (Type) JOHN F. SCHAEFFER | | 22d ADDRESS 401 RANDOM RD. BALTO 29 MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/31/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR'S SIGNATURE John J. Tuckner & Sons | | 25a. REC'D BY REGISTRAR DATE OCT 31 '60 | |
| ADDRESS Balto Md | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kneass | |

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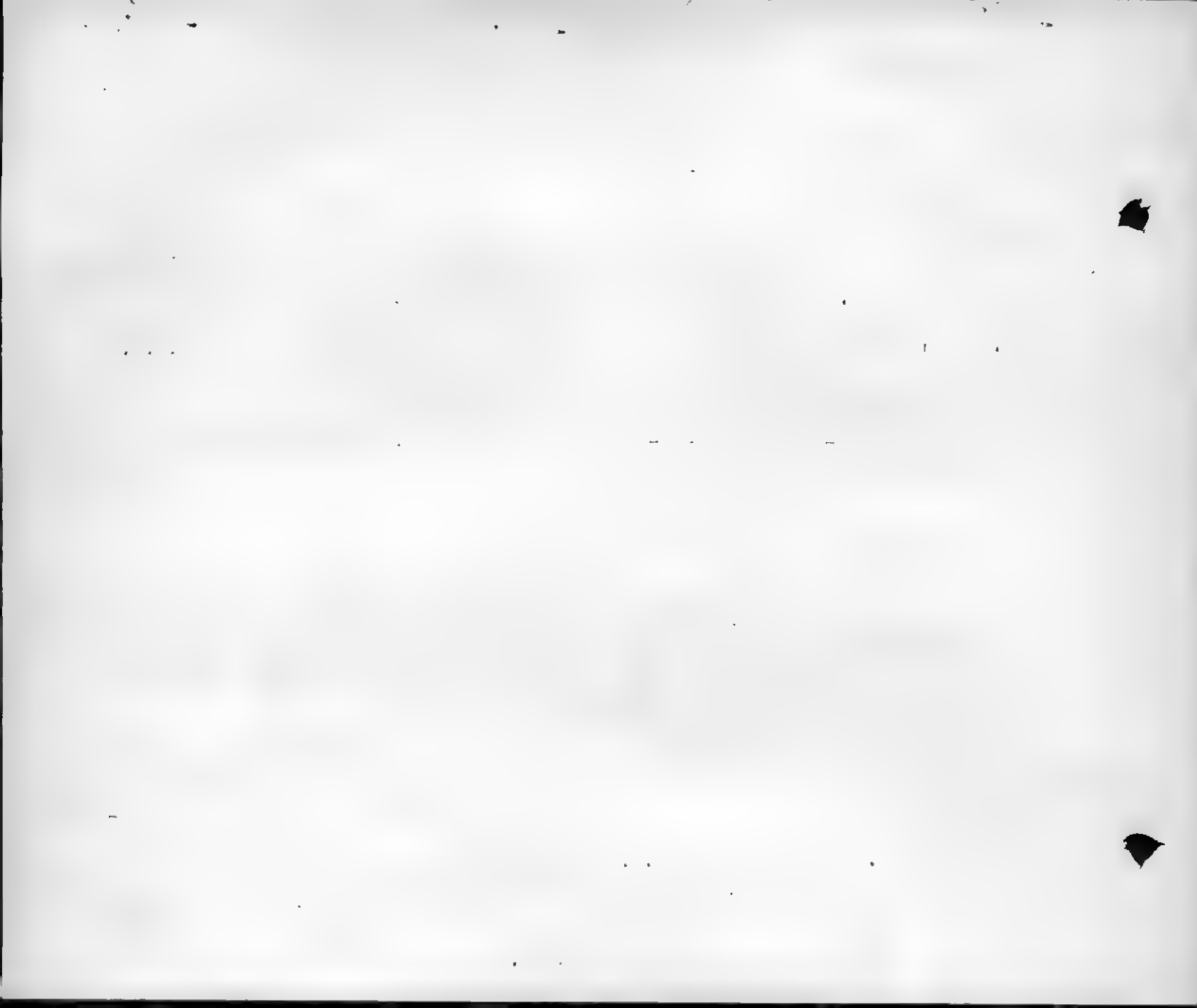
UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11114

11132

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | | | c. LENGTH OF STAY IN 1b 36 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | |
| | | | | d. STREET ADDRESS 1103 HARFORD AVENUE | | | |
| | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ROY Middle Last MATTHEWS | | | | 4. DATE OF DEATH Month October Day 22 Year 19 60 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE COLORED | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPTEMBER 16, 1891 | |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER'S HELPER | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME JAMES MATTHEWS | | | | 14. MOTHER'S MAIDEN NAME EMMA COLLINS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1 | | | | 16. SOCIAL SECURITY NO. 217-09-1492 | | 17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO MALNUTRITION Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. X FATTY LIVER X CARDIAC ARRITHMIA | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 25 DAYS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD HEAL PULMONARY TUBERCULOSIS | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 16, 1960 to October 22, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 22, 1960 , and that death occurred at 11:50 a.m., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>M. Lawrence Rubin</i> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 10-23-60 | |
| 22c. PHYSICIAN'S NAME (Type) M. LAWRENCE RUBIN, M.D. | | | | 22d. ADDRESS VAH, BALTIMORE, MD. - FT HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 24, '60 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Charles B Lewis Funeral Home | | | | 25a. REC'D BY REGISTRAR OCT 27 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraw</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11115

Reg. Dist. No.

11133

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowley's Quarters</u> | | c. LENGTH OF STAY IN 1b <u>Chase</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seneca Park Rd.</u> | | | d. STREET ADDRESS <u>Rt. 16 Box 247 Ebenezer Rd.</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Messenger</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1960</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 2, 1904</u> | | 9. AGE (In years last birthday) <u>55</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Highway</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> |
| 13. FATHER'S NAME <u>John Messenger</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Draayer</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Myrtle M. Messenger</u> Address <u>Rt. 16 Box 247</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (b) _____ DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chase</u> | |
| | | 20f. (City or town) <u>Chase</u> | | (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>M.B. Davis</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>10/5/60</u> | |
| EXAMINER'S NAME (Type) <u>M.B. Davis</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-8-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u> | |
| | | | | 22d. LOCATION (City, town, or county) <u>Chase, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> | | ADDRESS <u>7401 Belair Rd.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 6 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Chas. E. K...</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



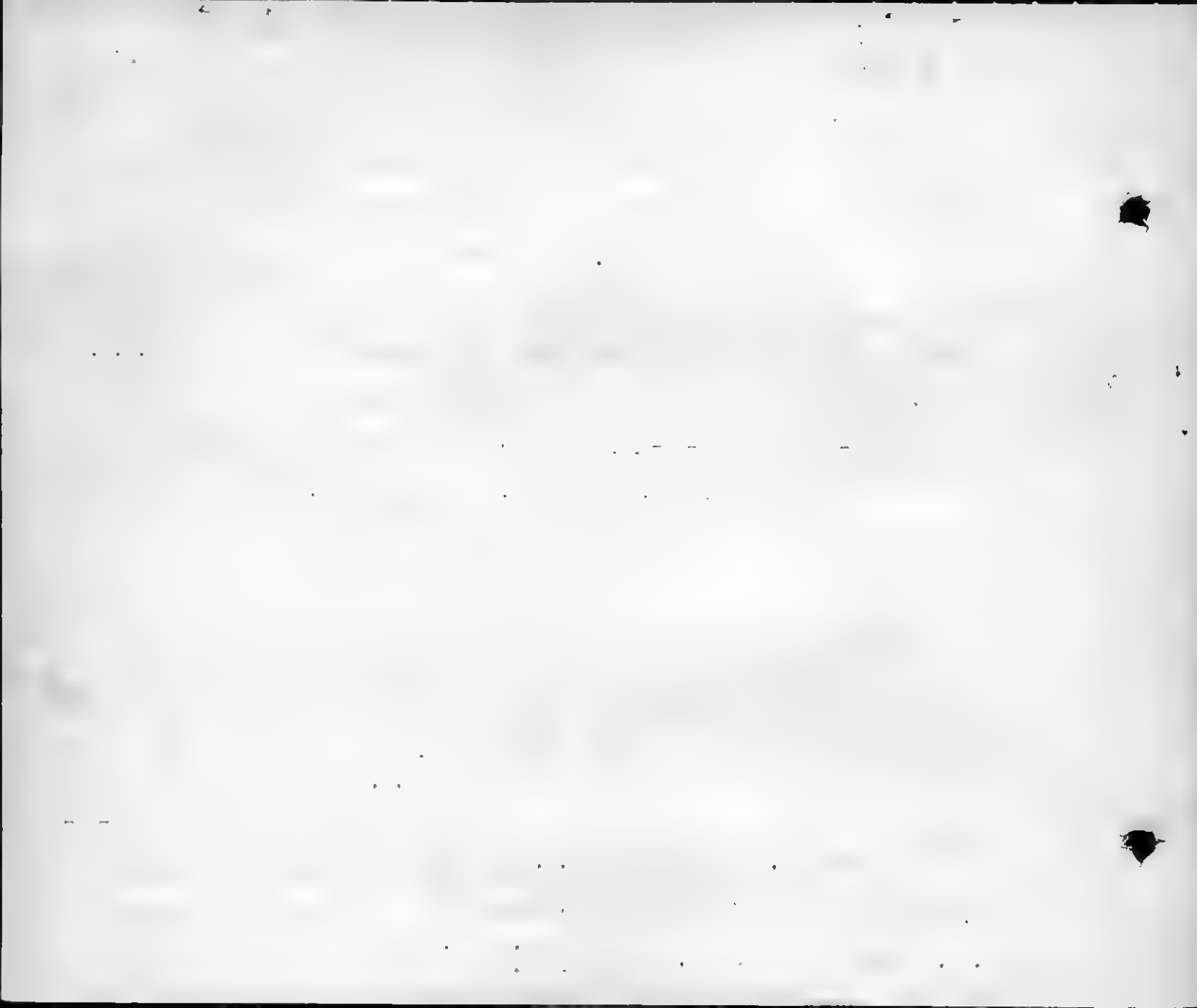
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

111134

11116

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | | | c. LENGTH OF STAY IN 1b 3 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS' ADMINISTRATION HOSPITAL | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last MEYER | | | | 4. DATE OF DEATH Month October Day 21 Year 19 60 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUGUST 22 1908 | |
| 9. AGE (In years last birthday) 52 yrs. | | 10. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME OTTO C. MEYER | | | | 14. MOTHER'S MAIDEN NAME LOUISE ULLMAN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO WW-11 215-05-6313 | | 17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SARCOMA, METASTATIC, INVOLVING LIVER 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMACIATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 18, 1960 , to October 21, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 21, 1960 , and that death occurred at 1:25 p.m. , from the causes and on the date stated above. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 22a. SIGNATURE ERNEST O. BROWN | | | | 22b. DATE SIGNED 10-21-60 | | | |
| 22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN | | | | 22d. ADDRESS M.D. VAH BALTO 18 MD - FT HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) EMERGENCY Removal | | 23b. DATE THEREOF 10/24/60 | | 23c. NAME OF CEMETERY OR CREMATORY SAINT MARY'S CEMETERY | | 23d. LOCATION (City, town, or county) (State) KINGSTON NEW YORK | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc. Baltimore, Md. | | | | 25a. REC'D BY REGISTRAR OCT 24 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. House | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be required by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

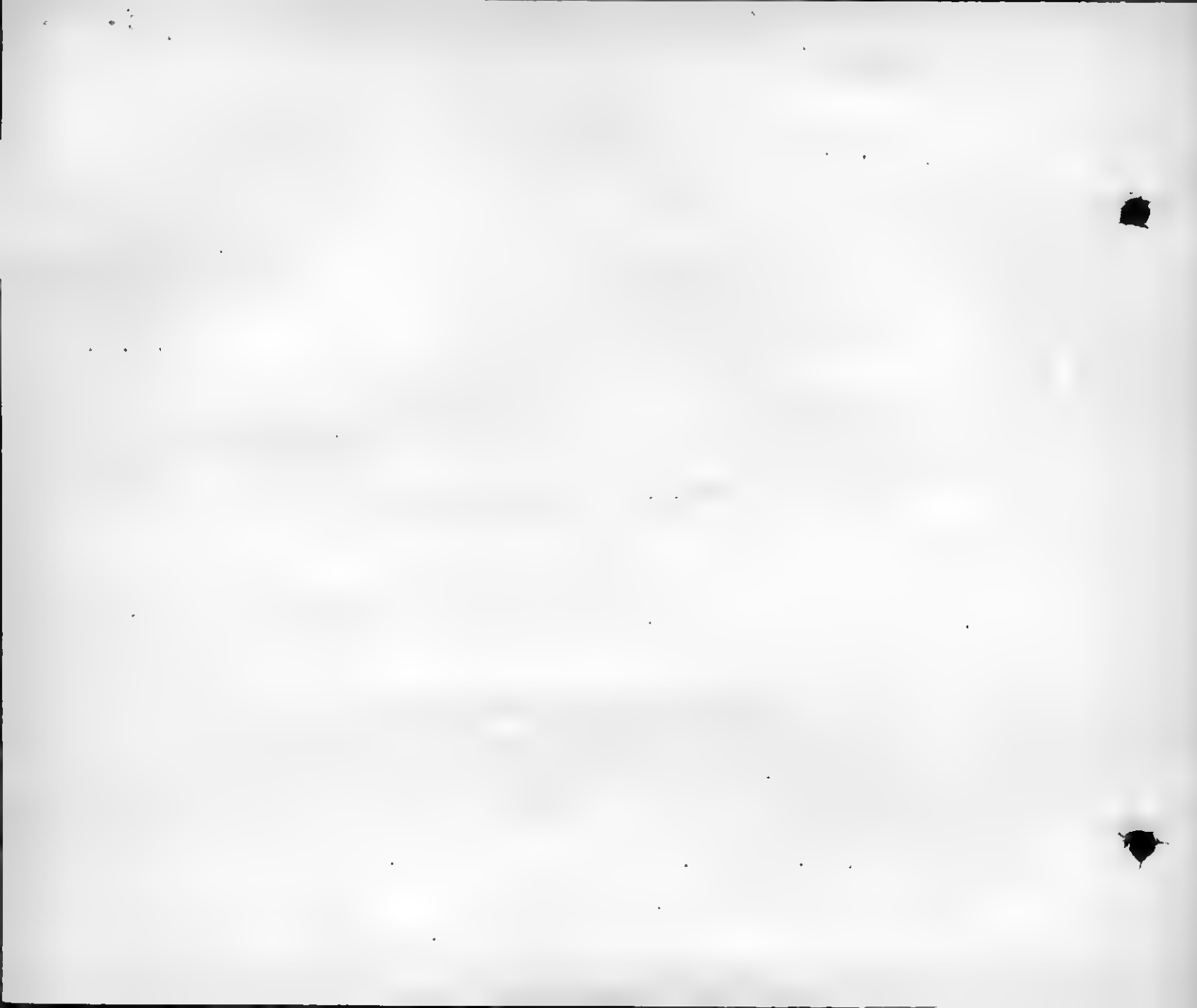
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

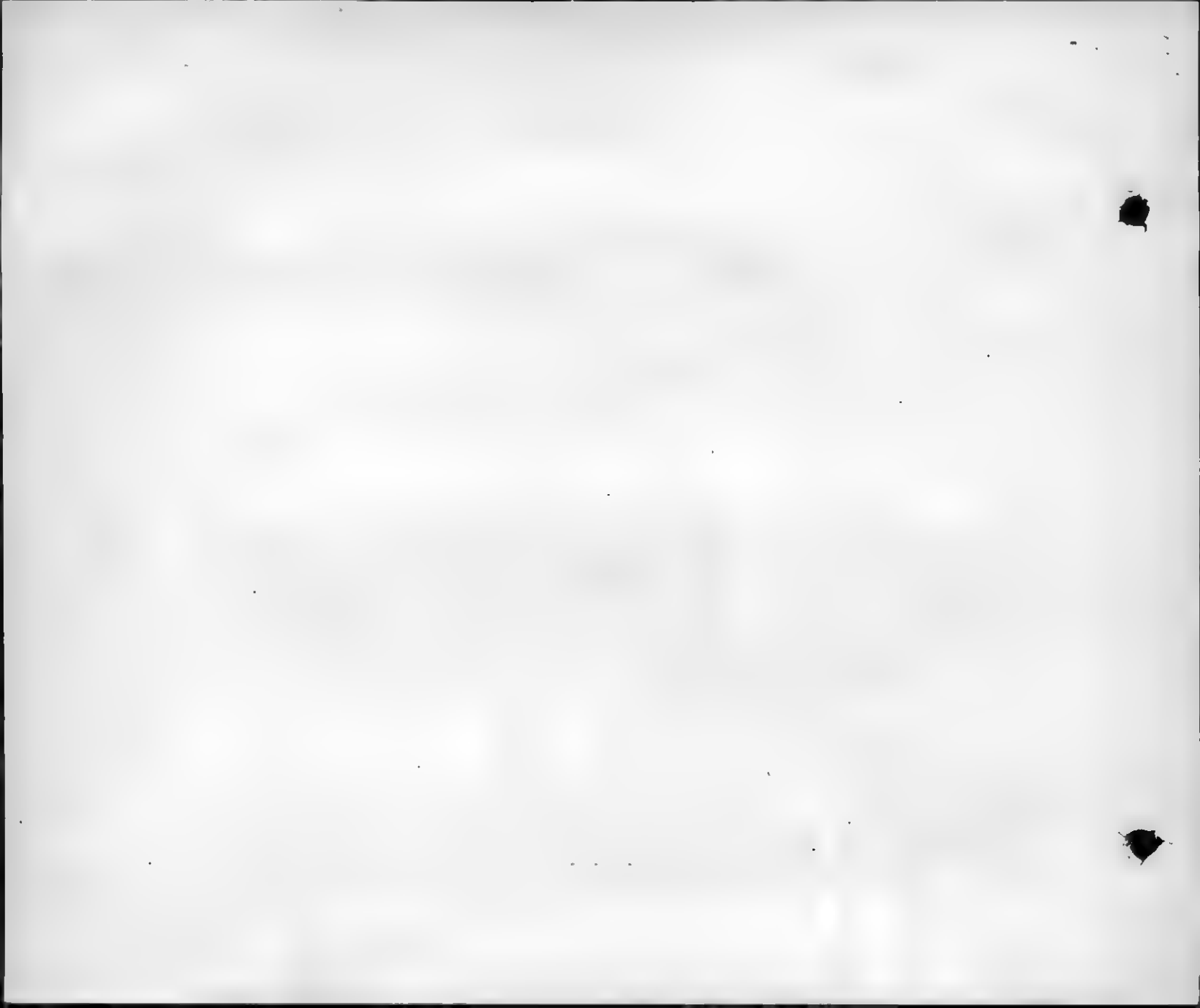
11135

11117

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | | | c. LENGTH OF STAY IN 1b 30 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 1622 Ellamont Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ISAAC Middle ---- Last MIDGETT | | | | 4. DATE OF DEATH Month October Day 19 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 17, 1885 | |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | | | 10b. KIND OF BUSINESS OR INDUSTRY Hotel | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Winslow Midgett | | | | 14. MOTHER'S MAIDEN NAME Matilda Crooms | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | | | 16. SOCIAL SECURITY NO. 86-10-1900 | | 17. INFORMANT Clinical Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO BRONCHOGENIC CARCINOMA, RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Acute Membranous Colitis. (b) 2. Arteriosclerosis, marked, generalized. (c) 3. Benign Prostatic Hypertrophy | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (X) (this hospital) attended the deceased from September 28, 1960 to October 19, 1960 , that (X) (we) last saw the deceased alive on 10/19, 1960 , and that death occurred at 2:55 A. M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE FREDERICK S. DONALDSON M.D. | | | | 22b. DATE SIGNED 10/19/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | | | 22d. ADDRESS VAH, BALTO. 18 MD, FORT HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/24/60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. | | | | 25a. REC'D BY REGISTRAR OCT 26 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

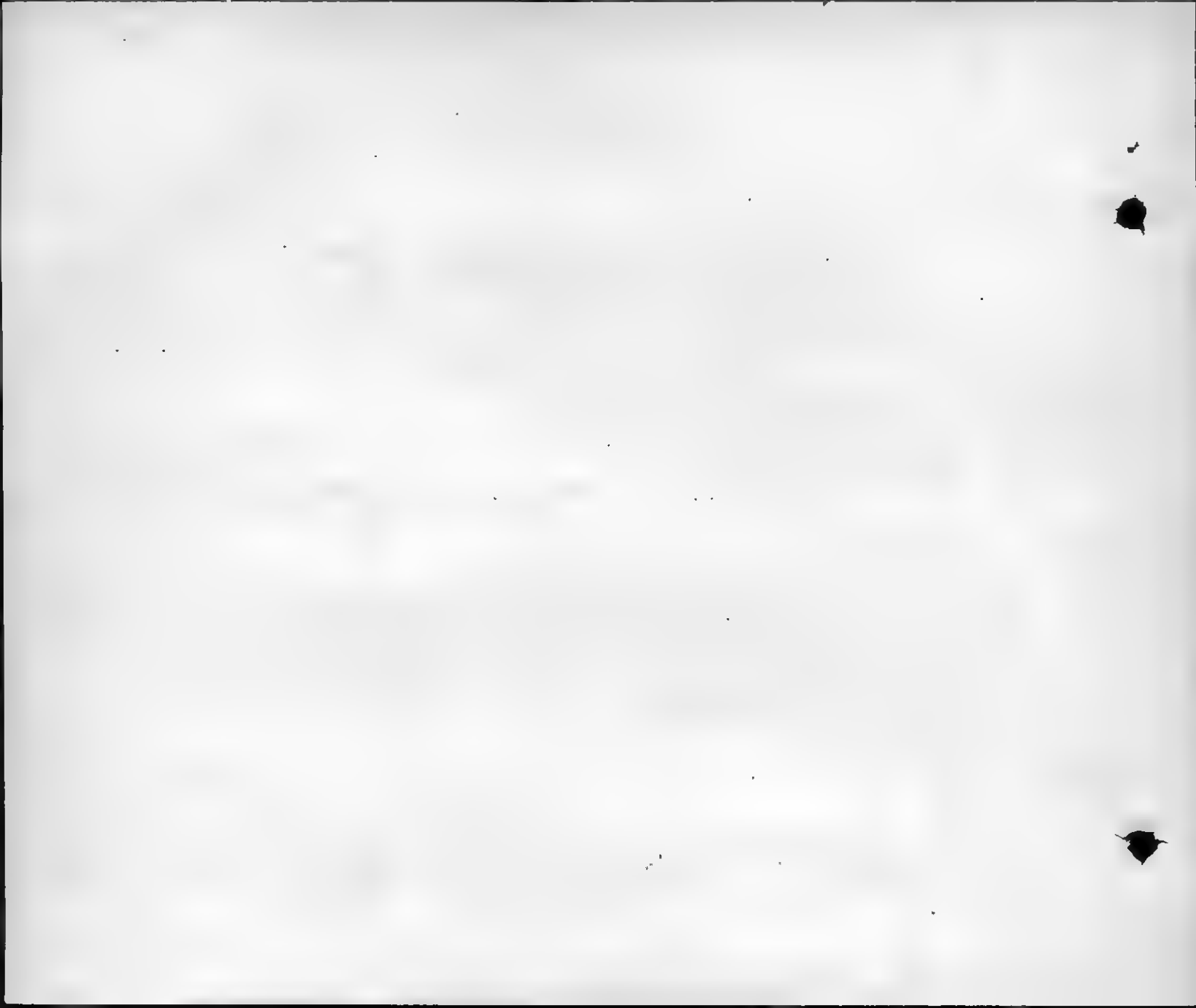
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11137

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11119

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 51 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | | | d. STREET ADDRESS 2593 W. Baltimore St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JAMES | | First C Middle MONTGOMERY | | Last DEATH | | 4. DATE Month October Day 28 Year 1960 | |
| 5 SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 5, 1904 | |
| 9 AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender | | | | 10b. KIND OF BUSINESS OR INDUSTRY Tavern | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William P. Montgomery | | | | 14. MOTHER'S MAIDEN NAME Anna L. Carey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. WW-11 215-01-6217 | | 17. INFORMANT Clin. Rec. VAH Balto Md. Fort Howard Division | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA OF TONGUE WITH METASTASIS TO NECK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 3 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition, Anemia | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 17, 1960 to Oct. 28, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 28, 1960 , and that death occurred at _____ M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Lawrence D. Marcus, M.D. | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS, M.D. | | | | 22d. ADDRESS VAH, Baltimore 18, Md. Fort Howard Division | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-2-60 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | | | 25a. REC'D BY REGISTRAR NOV 1 '60 | | 25b. REGISTRAR'S SIGNATURE Charles S. Kline | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please so indicate the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

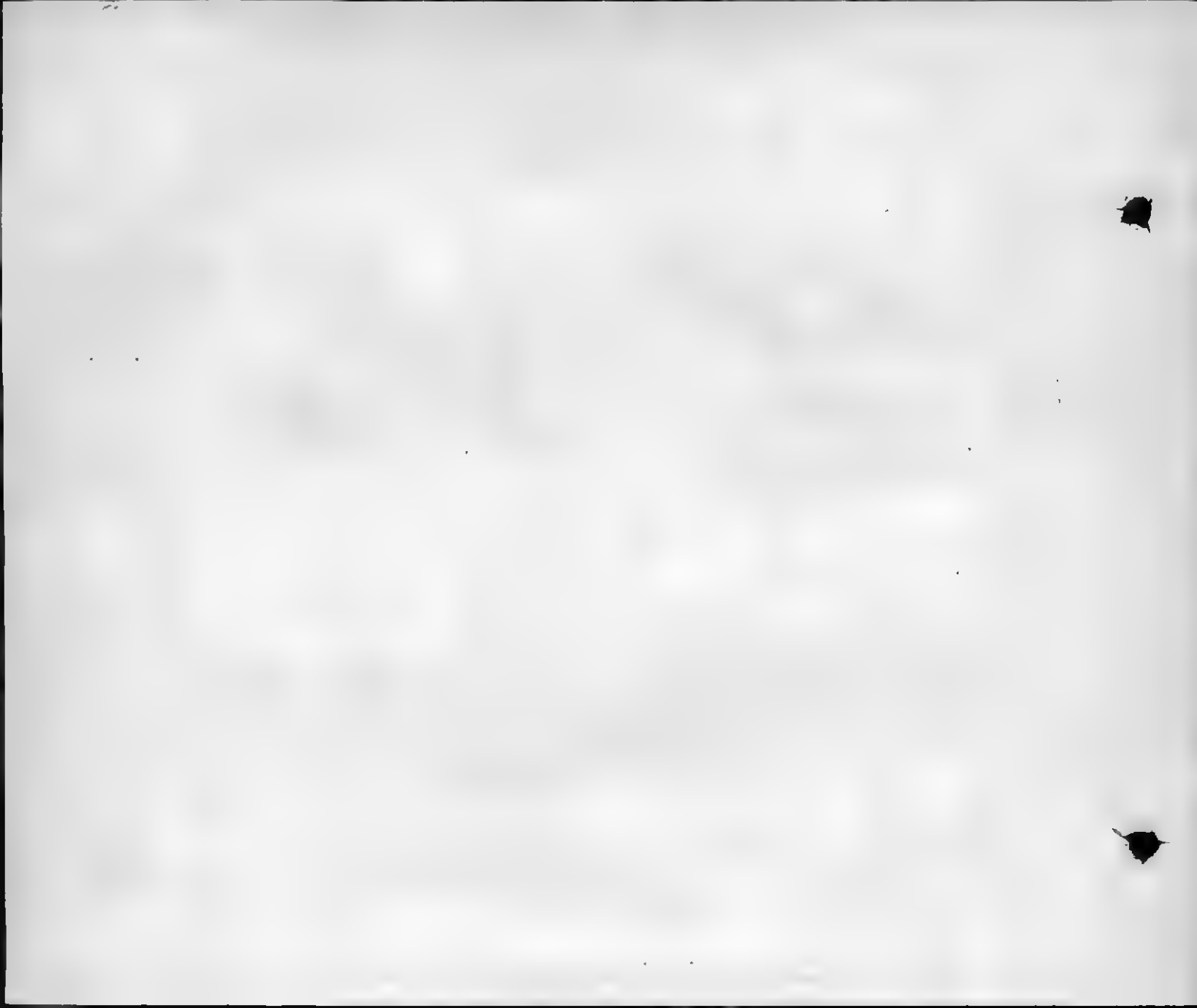
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

111138

Reg. Dist. No. 111120

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penwood Terrace | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penwood Terrace | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 10, Box 644, Thomas Lane | | | | d. STREET ADDRESS Route 10, Box 644, Thomas Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) NAOMI LOUISE MOORE | | | | 4. DATE OF DEATH Month October Day 2 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 16, 1909 | |
| 9. AGE (In years last birthday) 51 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Louis L. Berends | | | | 14. MOTHER'S MAIDEN NAME Fredericka Broghammer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. Harry E. Ritter 1925 Eastfield Road | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by Hanging - 9777 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 Hrs | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour 19 o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Jack O Collins | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) JACK O COLLINS | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/7/60 | | 22c. NAME OF CEMETERY OR CREMATORY Moreland Park | | 22d. LOCATION (City, town, or county) (State) Parkville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jllrich Funeral Home Dundalk, Md. | | | | 24a. REC'D BY REGISTRAR OCT 6 '60 | | 24b. REGISTRAR'S SIGNATURE Carlton S. Hume | |

10-4-60



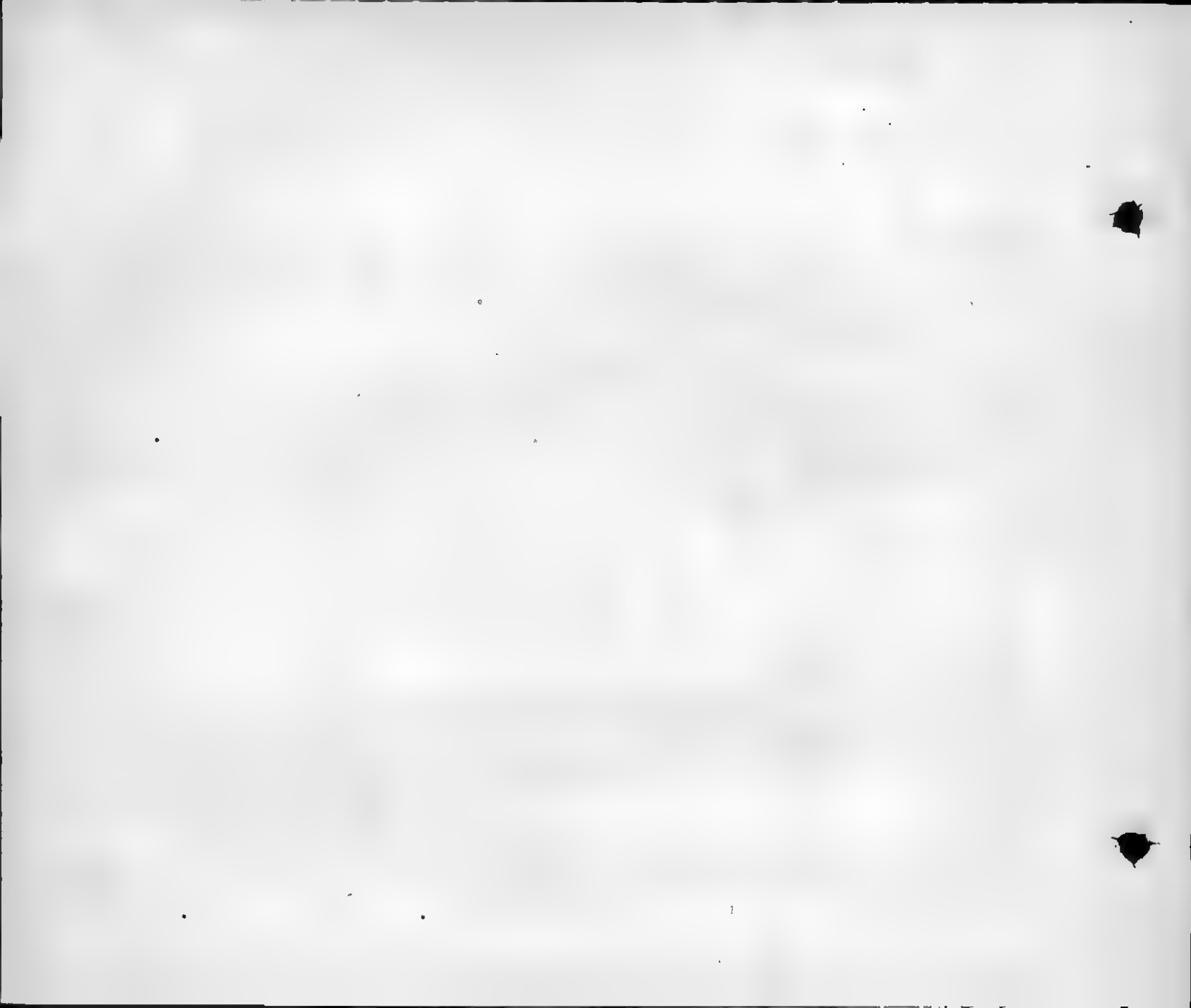
11139

CERTIFICATE OF DEATH

11121

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4 (Towson)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 4 (Towson) 35</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>306 W. Joppa Rd.</u> | | d. STREET ADDRESS <u>306 W. Joppa Road</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>T. Gertrude Moran</u> | | 4. DATE OF DEATH Month Day Year <u>October 21, 1960</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 12, 1877</u> |
| 9. AGE (In years last birthday) yrs. <u>83</u> | | IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Arthur Chenoweth</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Schwartz</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Dora Coale</u> | | Address <u>306 W. Joppa Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Anterior Sclerosis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Breast</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. st. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July, 1946</u> to <u>21 Oct, 1960</u> , that I last saw the deceased alive on <u>21 Oct, 1960</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Charles H. T. [Signature]</u> | | DATE SIGNED <u>4-7-61 York Td Baltimore 22 Oct 1960</u> | |
| PHYSICIAN'S NAME (Type) <u>Thomas H. T. [Signature] M.D.</u> | | M.D. <u>md. 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 24, '60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Towson, Balto. 4, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>vm. Brook-Towson, Inc.</u> | | ADDRESS <u>1050 York Rd.</u> | |
| 24a. REC'D BY REGISTRAR <u>OCT 25 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u> | |



1
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

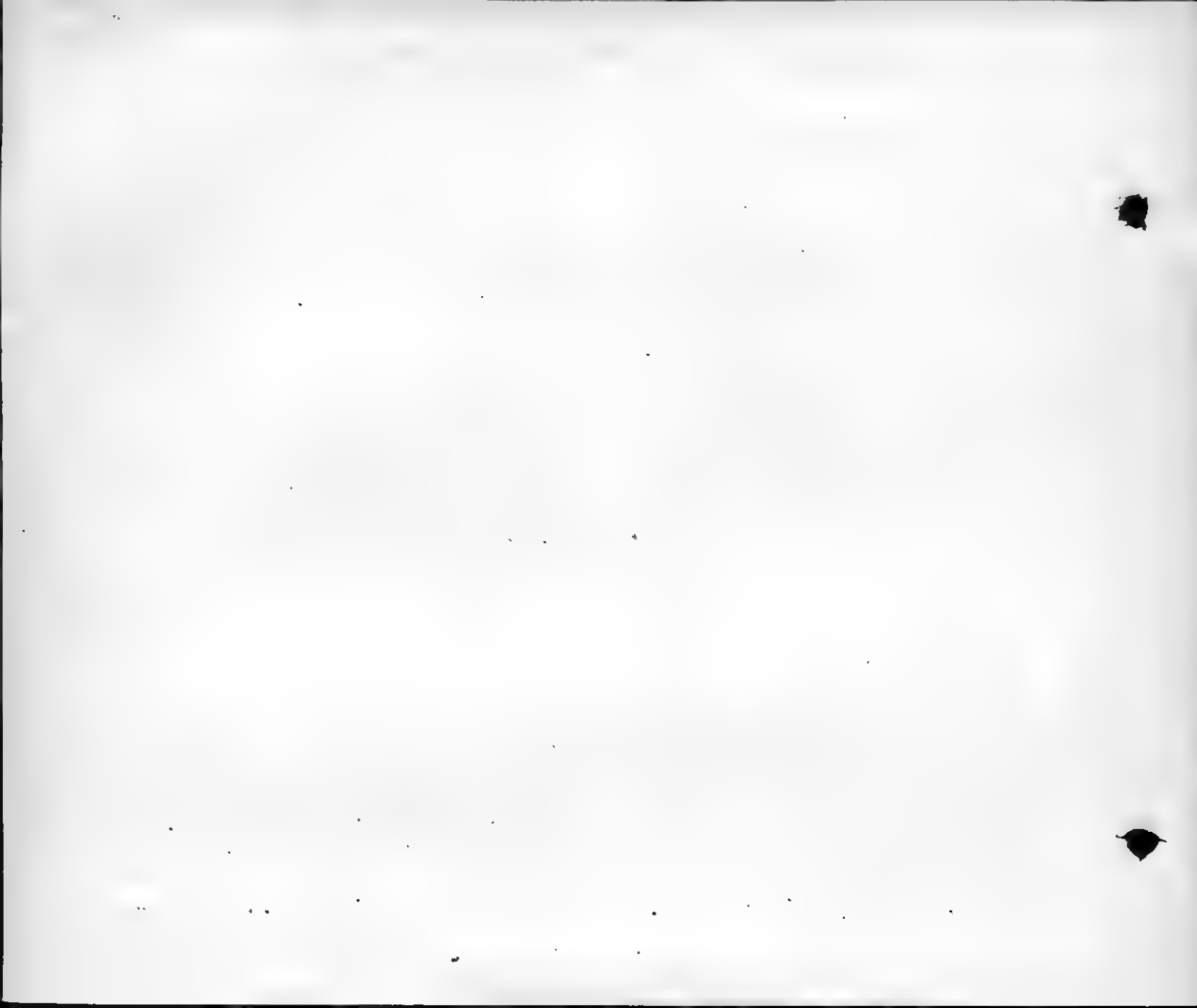
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11122
Reg. Dist. No.

11140

| | | | |
|---|------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GA ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN PINES | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN 250 2 | |
| d. STREET ADDRESS 206 R. N. ... Rd | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle M. Last MORRISSEY | | 4. DATE OF DEATH Month 10 - Day 15 - Year 1960 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 27, 1887 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret | | 10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal Worker | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Harry MORRISSEY | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. - | |
| INFORMANT FAMILY | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension, essential, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 years (c) 12 hrs | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1954 19... to 10-15 19 60 , that I last saw the deceased alive on OCT 15 19 60 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5010 A Ritchie Hwy DATE SIGNED Balkis M.D. | | | |
| ACTUAL SIGNATURE Begun Berdum M.D. 5010 A Ritchie Hwy | | | |
| PHYSICIAN'S NAME (Type) Balkis M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-19-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Green Haven Cem | | 22d. LOCATION (City, town, or county) (State) Green Haven, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes | | ADDRESS 130 E. Fort Ave | |
| 24a. REC'D BY REGISTRAR OCT 20 1960 | | 24b. REGISTRAR'S SIGNATURE Arthur S. ... | |



1-
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and file any event within 72 hours after death.

V5. A15ME
5M 7/59

Item 18 Film 274 11-9

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11141 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12304

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Overlea**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **6003 Westwood Avenue**

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Overlea**
d. STREET ADDRESS **6003 Westwood Avenue**

3. NAME OF DECEASED (Type or print) **FLORENCE VIRGINIA MOSCIARELLA**
4. DATE OF DEATH **October 13 1960**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **Mar. 2, 1948** 9. AGE (In years last birthday) **12** yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **SCHOOL GIRL** 10b. KIND OF BUSINESS OR INDUSTRY **—** 11. BIRTHPLACE (State or foreign country) **BALTIMORE MD** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **AUGUST J MOSCIARELLA** 14. MOTHER'S MAIDEN NAME **FLORENCE FINNICK**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **NONE** 17. INFORMANT **AUGUST J. MOSCIARELLA** Address **6003 WESTWOOD AVE**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **525X** DUE TO **Interstitial pneumonia**
Conditions, if any, which gave rise to immediate cause (b) **—**
(a), stating the underlying cause last. DUE TO (c) **—**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **—** 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) **—**

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **—** 20f. (City or town) (County) (State)

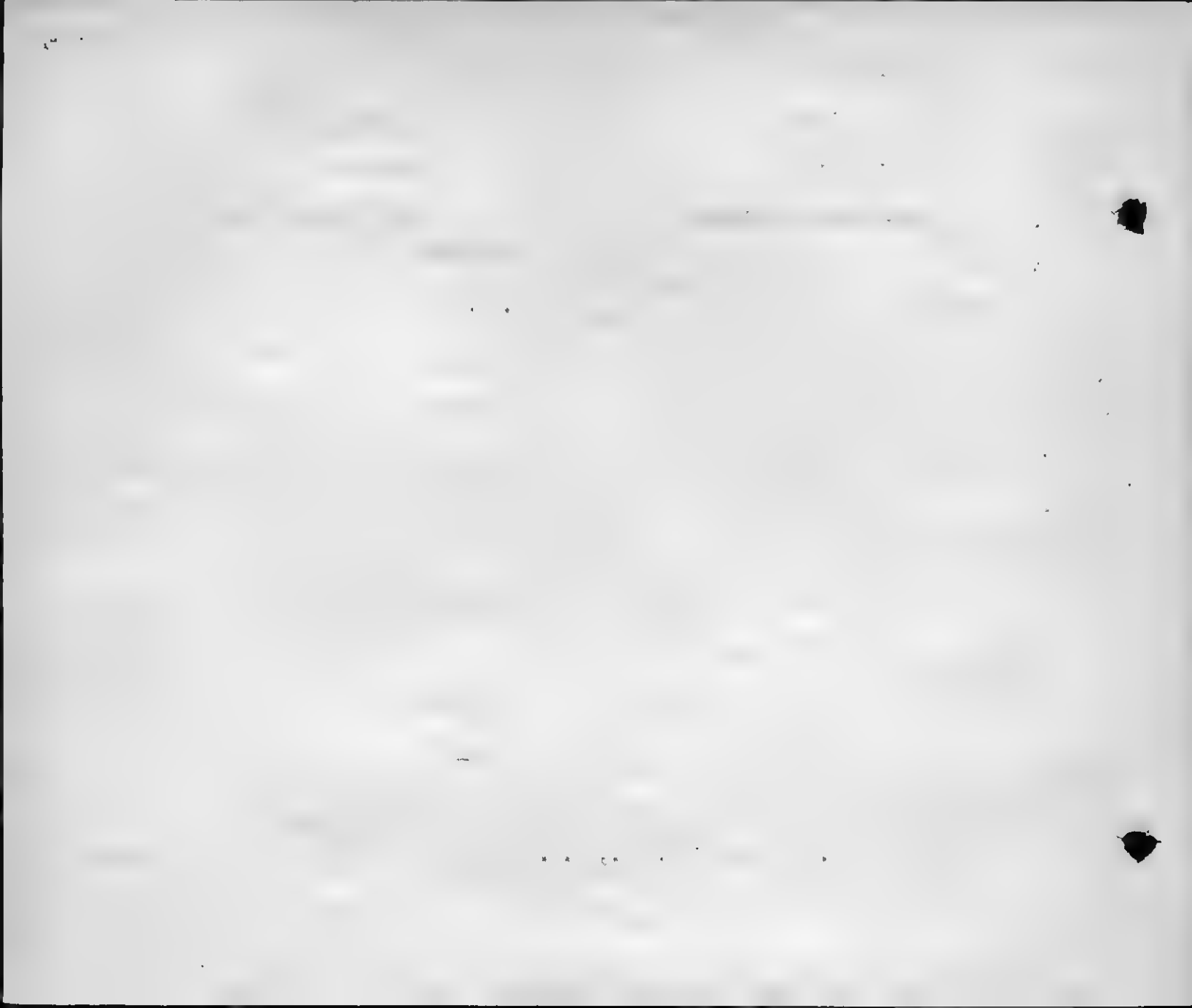
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **W. Bradley King, Jr., M.D.** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **10/13/60**

EXAMINER'S NAME (Type) **W. Bradley King, Jr., M.D.** Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **OCT 17 1960** 22c. NAME OF CEMETERY OR CREMATORY **HOLY REDEEMER CEM** 22d. LOCATION (City, town, or country) (State) **4430 BELAIR RD MD**

23. FUNERAL DIRECTOR **Sappel Bros. 7110 Belair Rd.** ADDRESS **—** 24a. REC'D BY REGISTRAR **OCT 17 '60** 24b. REGISTRAR'S SIGNATURE **Arthur S. Frank**



11142

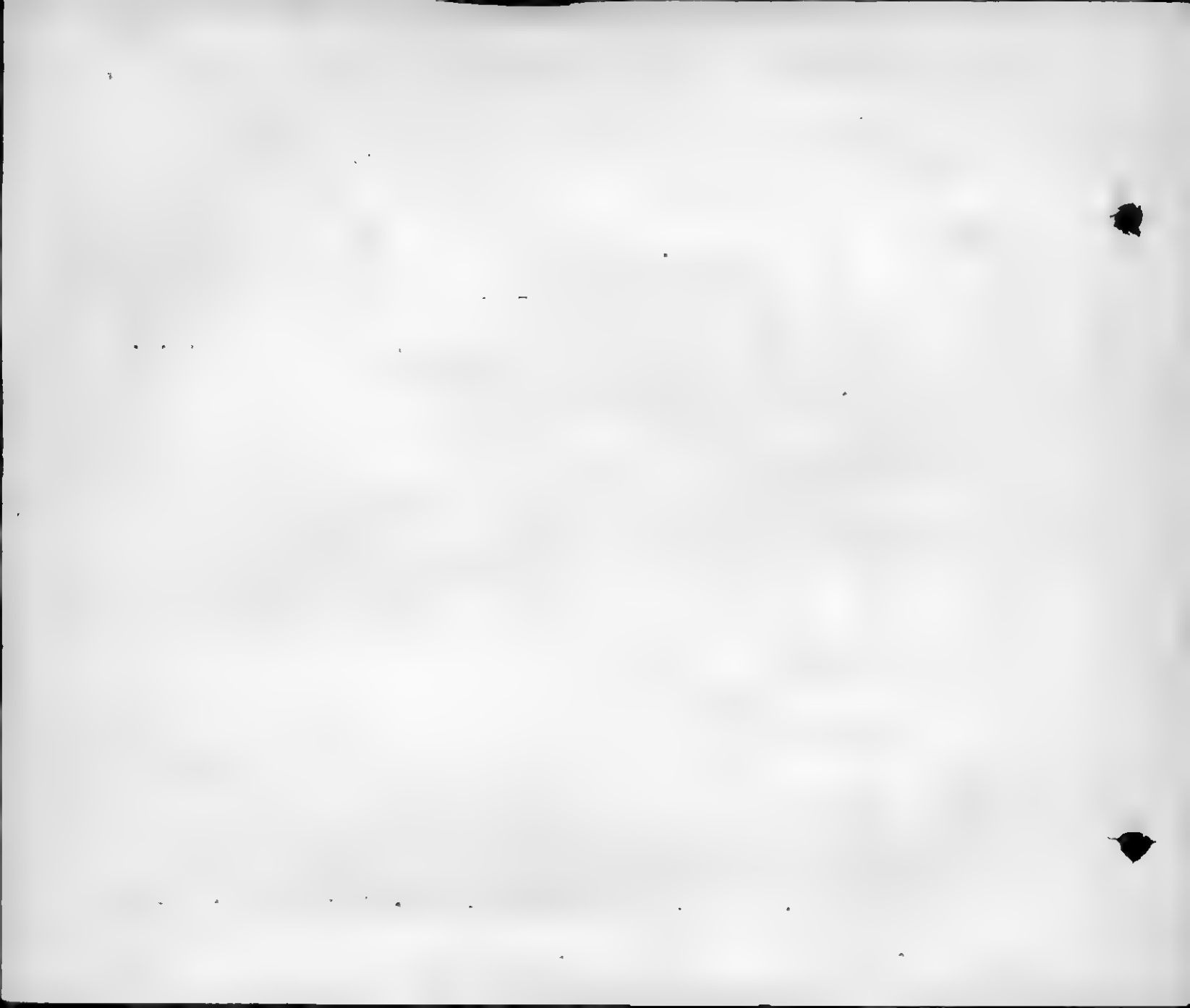
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowleys Quarters | | c. LENGTH OF STAY IN lb lyr | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 479 A Burke Road | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| | | d. STREET ADDRESS 479A Burke Road | |
| 3. NAME OF DECEASED (Type or print) First Clyde Middle H. Last Mould | | 4. DATE OF DEATH Month Oct Day 1 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-22-1905 |
| 9. AGE (In years last birthday) yrs. 55 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Kingston, New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph E. Mould | | 14. MOTHER'S MAIDEN NAME Emma Haver | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes War 11 | | 16. SOCIAL SECURITY NO. Mr Hook 479A Burke Road | |
| 17. INFORMANT Mr Hook 479A Burke Road | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary embolism 450 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic vascular disease DUE TO (c) gangrene right leg | | INTERVAL BETWEEN ONSET AND DEATH Immediate 3 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 30, 1960 to Oct 1, 1960 , that I last saw the deceased alive on Sept 30, 1960 , and that death occurred at 9 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Louis Semenov | | ADDRESS (Street, city or town, state) 2108 CREMS RD DATE SIGNED 10/1/60 | |
| PHYSICIAN'S NAME (Type) Louis SEMENOV | | Balto 20, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct 5, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | 22d. LOCATION (City, town, or county) (State) Frederick Rd. Balto Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE LEO G. COOK | | ADDRESS 1701 PATTERSON PK. AVE | |
| 24a. REC'D BY REGISTRAR DATE OCT 7 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knease | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

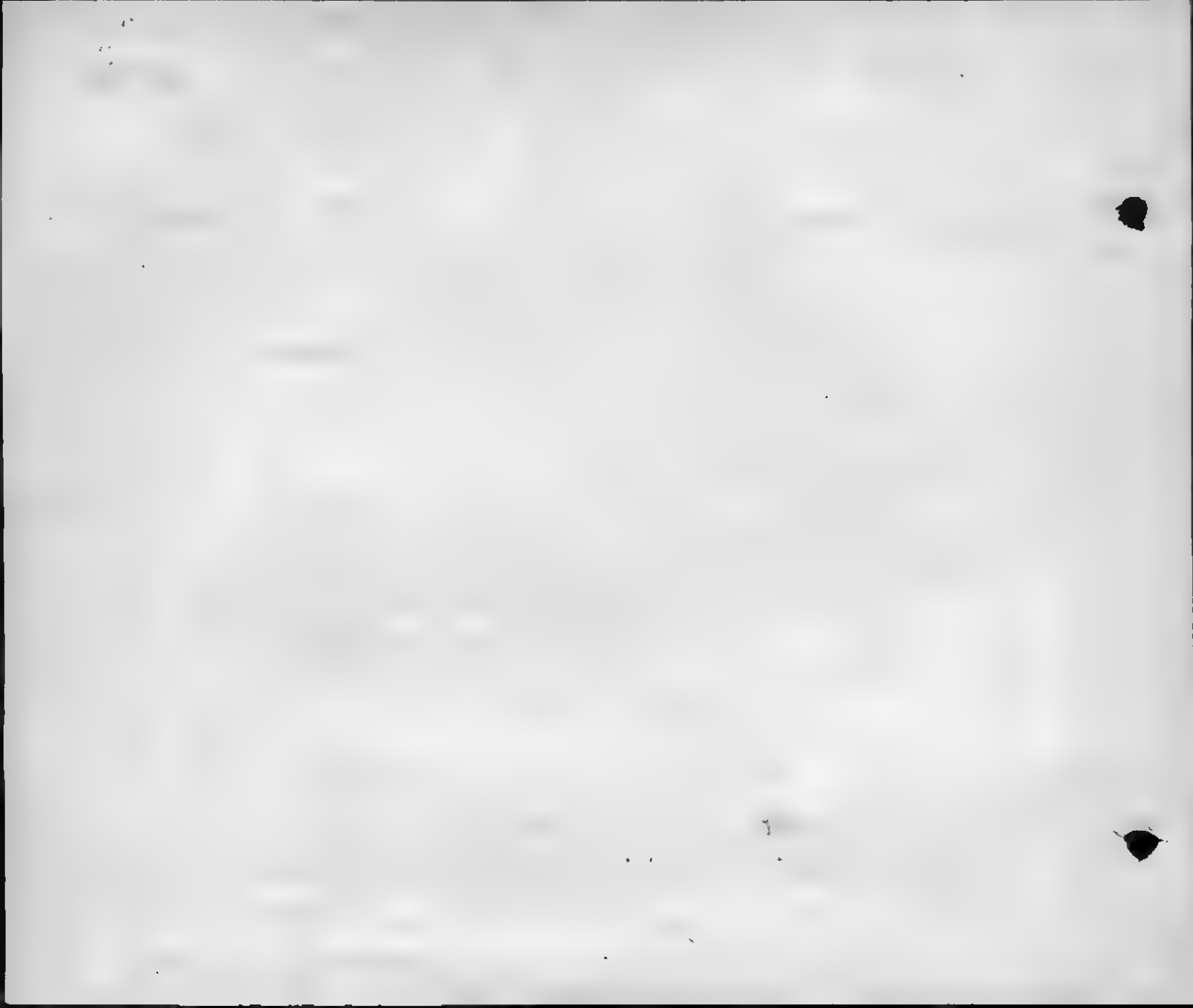
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| <div> <div>18-21 Film 273</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>11143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11124</div> </div> | | | | | | | | | | |
|--|--|----------------------------------|---|--|--|------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 415 Edgewater Apts. | | | | | d. STREET ADDRESS 415 Middle River Edgewater Apts. | | | | | |
| 3. NAME OF DECEASED (Type or print) DOTTIE ANN MUIR | | | | | 4. DATE OF DEATH October 3, 1960 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/15/60 | | 9. AGE (In years last birthday) 17 yrs. IF UNDER 1 YEAR: Months 17 Days 17 Hours 17 Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland BALTIMORE CITY | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME James Muir | | | | | 14. MOTHER'S MAIDEN NAME Lois Ann Pressman | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. None | | | | | |
| 17. INFORMANT James Muir | | | | | Address Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonia 7-3-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher M.D. | | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | | 22b. DATE THEREOF 10/4/60 | | 22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery | | 22d. LOCATION (City, town, or country) Frostburg, Maryland (State) _____ | |
| 23. FUNERAL DIRECTOR James Pruzanski | | | | | ADDRESS 1407 Eastern Ave. | | | | | |
| 24a. REC'D BY REGISTRAR OCT 5 '60 | | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | | | |



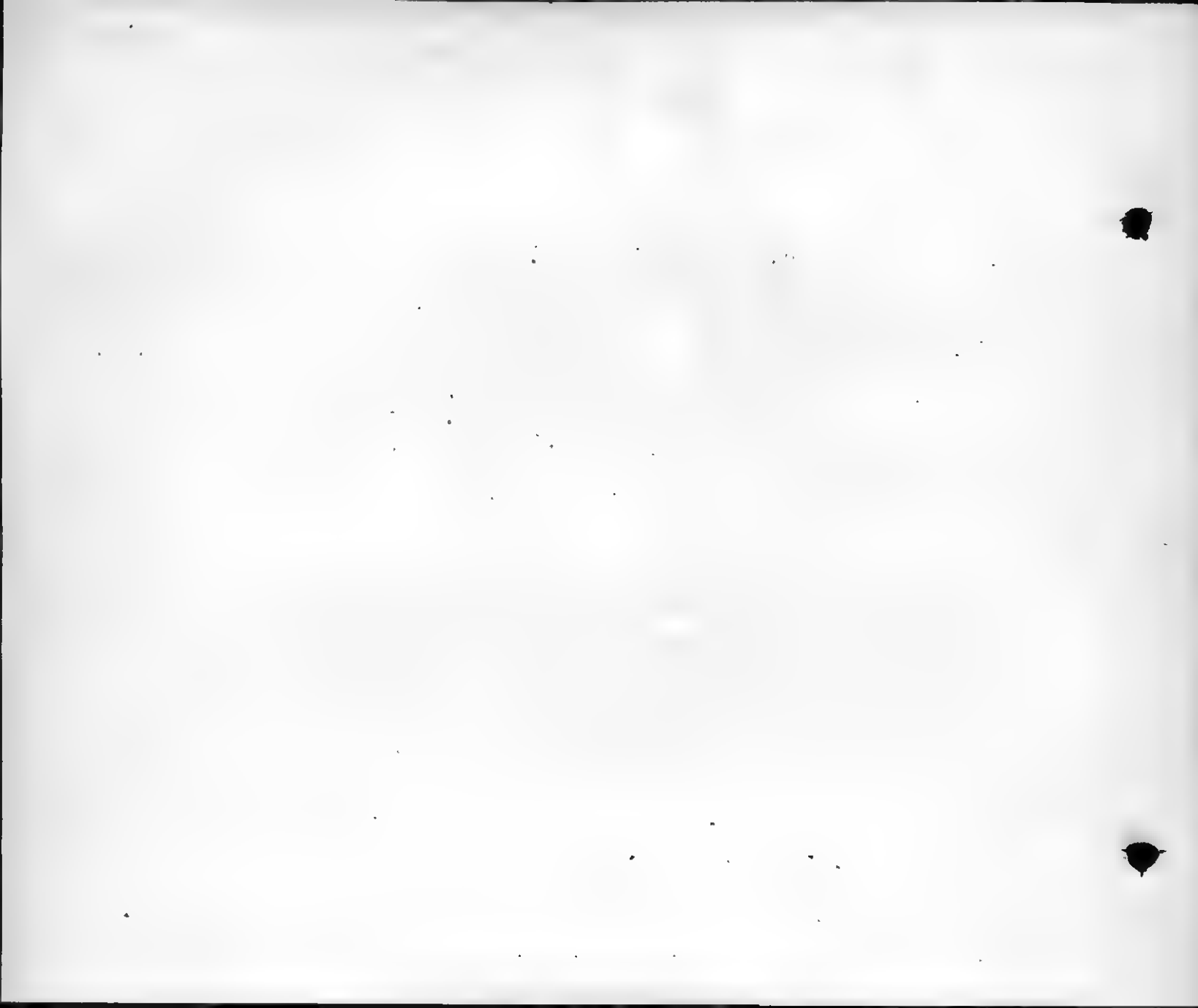
CERTIFICATE OF DEATH

Reg. Dist. No. 11125

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | c. LENGTH OF STAY IN lb LIFE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8102 EASTERN AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MELVIN N. MYERS (MEYERS) | | 4. DATE OF DEATH Month Day Year OCTOBER 23, 1960 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 31, 1910 |
| 9. AGE (In years last birthday) 50 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIPPER & CAULKER | | 10b. KIND OF BUSINESS OR INDUSTRY BETH STEEL CO | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES MYERS | | 14. MOTHER'S MAIDEN NAME EMMA SACHS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WORLD # 2 213 09 3141 | |
| 17. INFORMANT MRS LAURA W. MYERS | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas and liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from 4-2-60 , 1960, to 10-23 , 1960, that I last saw the deceased alive on 10-22 , 1960, and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE John J. Gould M.D. 147960 | | 10-24-60 | |
| PHYSICIAN'S NAME (Type) JOHN J. GOULD | | Baltimore MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 10/27/60 | 22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY | 22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND |
| 23. FUNERAL DIRECTOR'S SIGNATURE HEARRY SANDER & SONS INC. BALTO. MD. | | 24a. REC'D BY REGISTRAR OCT 28 60 | |
| 24b. REGISTRAR'S SIGNATURE Conrad E. Hume | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the patient be released by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11145

11126

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> | | b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u> | | c. LENGTH OF STAY IN 1b <u>6 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt Carmel Rd</u> | | | | d. STREET ADDRESS <u>1 Mt Carmel Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First <u>Lillie</u> | | Middle <u>B</u> | | Last <u>Nash</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1960</u> | |
| 9. AGE (in years last birthday) <u>86</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Cagey Ensor</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Benson</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs Walter Mays</u> | | Address <u>Parkton Md</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>60 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 5</u> 19 <u>60</u> , to <u>Oct 7</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct 6</u> 19 <u>60</u> , and that death occurred at <u>2A</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Joseph E. Bush</u> M.D. | | | | 22b. DATE SIGNED <u>10-7-60</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> | |
| 22d. ADDRESS <u>Hamptstead Maryland</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10-9-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Methodist</u> | |
| 23d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson 4, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>OCT 10 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |



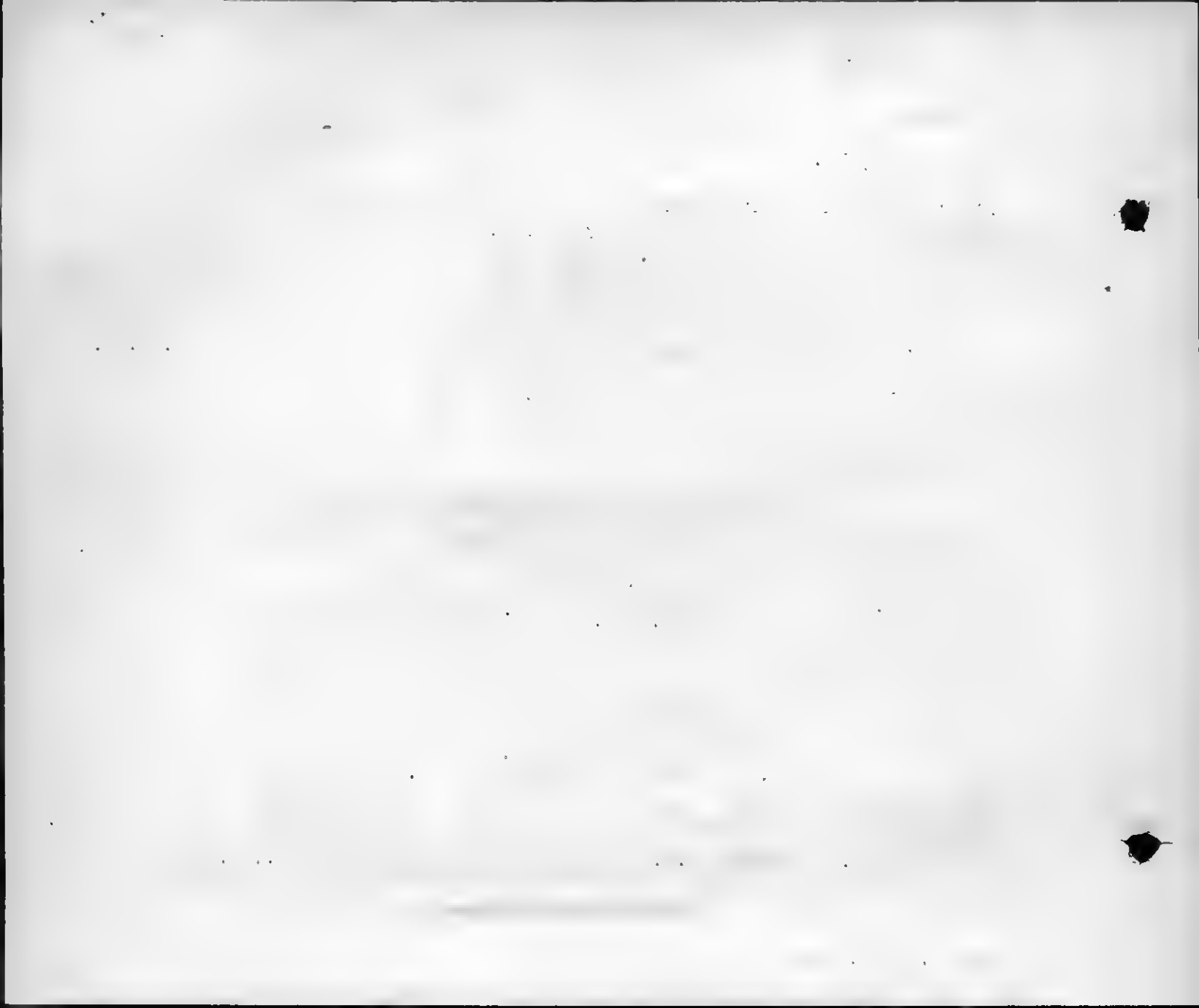
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|---------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 31 Days | | 2 USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (19) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First LEWIS Middle L. ----- Last (Notaronele) NOTARO | | 4. DATE OF DEATH Month October Day 19 Year 19 60 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 7, 1921 |
| 9. AGE (In years last birthday) 39 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Setter | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13 FATHER'S NAME Pietro Notaro | | 14. MOTHER'S MAIDEN NAME Catherine Aiello | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 215-14-8491 | |
| 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PERITONEAL ADHESIONS (POST OPERATIVE) ACUTE PEPTIC ULCER, STOMACH GASTROJEJUNOSTOMY, STENOTIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PIEURAL EFFUSION, LEFT EMACIATION, MARKED PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operations: EnterO-enterostomy. Old. 2. Ileostomy October, 1960 | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (X) (this hospital) attended the deceased from Sept. 28, 1960 , to Oct. 19, 1960 , that (X) (we) last saw the deceased alive on Oct. 19, 1960 , and that death occurred at P. 6:35 P. M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Fredrick S. Donaldson | | 22b. DATE 10/20/60 | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-22-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Duda, 7922 Wise Ave., Baltimore, Md. | | 25a. REC'D BY REGISTRAR DATE OCT 24 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |



CERTIFICATE OF DEATH

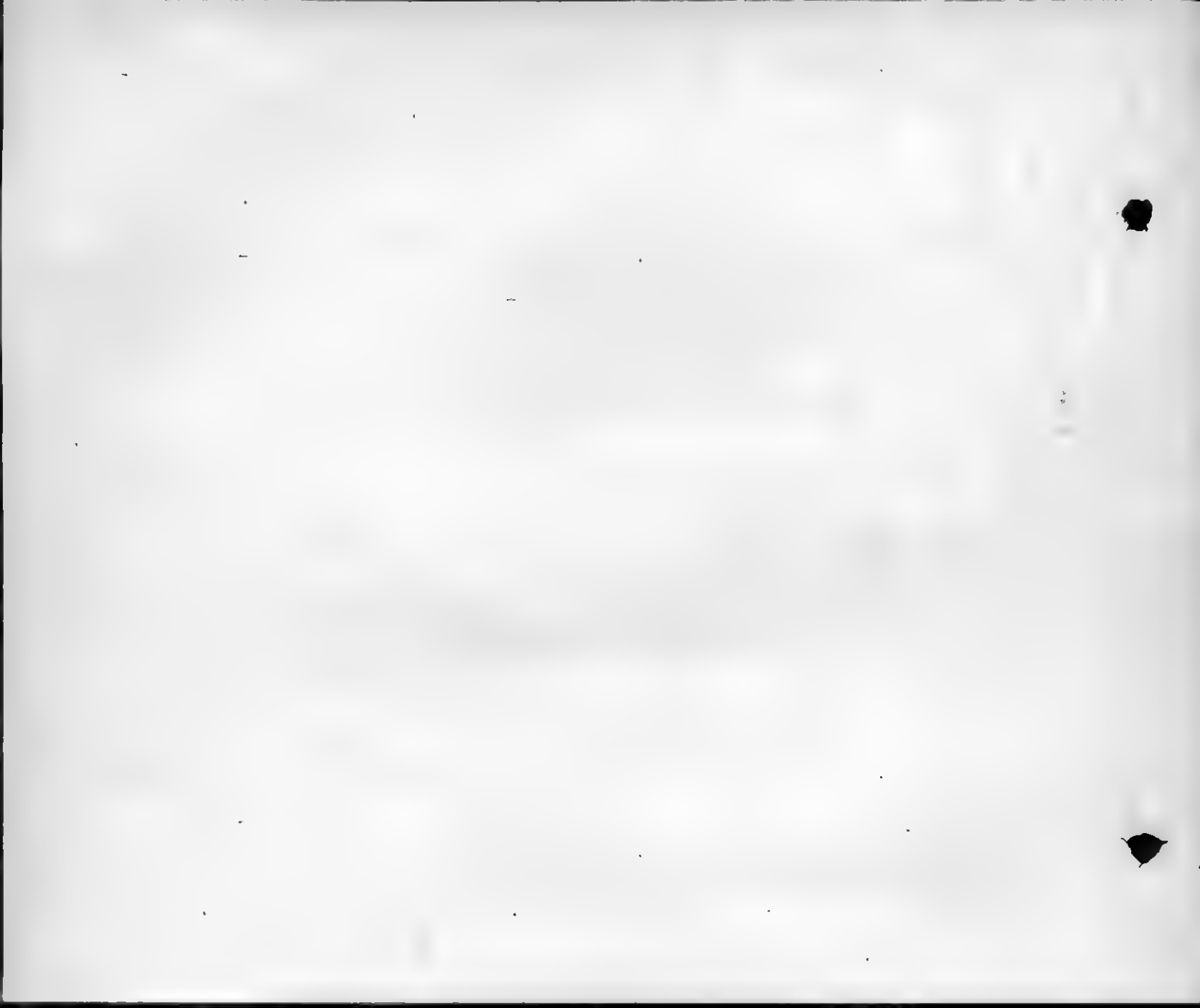
Reg. Dist. No.

11147

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| | | | |
|--|--------------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home House in the Pines Nursing</i> | | d. STREET ADDRESS <i>2402 Southern Ave.</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>Addie</i> Middle <i>B.</i> Last <i>O'Donnell</i> | | 4. DATE OF DEATH Month <i>10-</i> Day <i>10</i> Year <i>19 60</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-3-1883</i> |
| 9. AGE (In years last birthday) <i>77</i> yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 13. FATHER'S NAME <i>William Parks</i> | | 14. MOTHER'S MAIDEN NAME <i>Jenny (Unknown)</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <i>Gloria M. Grikit</i> | | Address <i>1325 Stevens Ave.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebro-Vascular Accident.</i> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>10/29, 1959</i> , to <i>10/10, 1960</i> , that I last saw the deceased alive on <i>10/10, 1960</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>J. N. Frederick</i> | | ADDRESS (Street, city or town, state) <i>1305 Francis Ave</i> | |
| PHYSICIAN'S NAME (Type) <i>J. N. Frederick M.D.</i> | | DATE SIGNED <i>Bo/to, 27, Md</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 22b. DATE THEREOF <i>10-13-60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Morland Mem. Park</i> | 22d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | ADDRESS <i>5305 Harford Rd.</i> | |
| 24a. REC'D BY REGISTRAR <i>Oct 13 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hunt</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be read by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

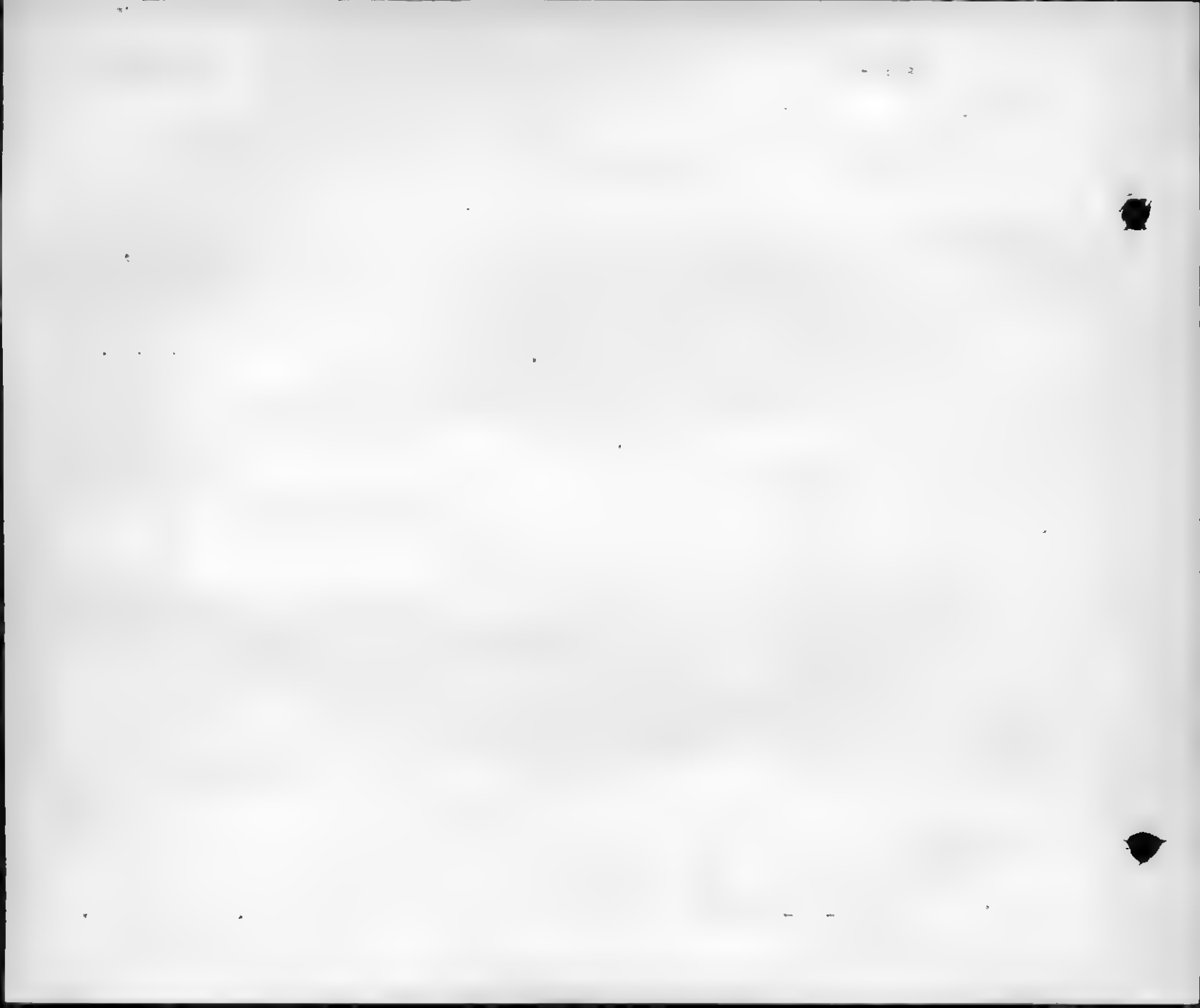
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CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Y | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 7yr7mth19dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore SV 11-11 | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | g. STREET ADDRESS 5217 Windsor Mill Road | |
| 3. NAME OF DECEASED (Type or print) First Marie Middle Margaret Last O'Donnell | | 4. DATE OF DEATH Month October Day 13 Year 19 60 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 26, 1889 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min 0 | 11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) packer | | 10b. KIND OF BUSINESS OR INDUSTRY The Parker Metal Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Bernard O'Donnell | | 14. MOTHER'S MAIDEN NAME Marie McGreevey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. 212-03-9917 | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppurative Meningitis DUE TO Gangrenous decubital ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 14, 1960 to 10.13, 1960 , that (I) (we) lost the deceased on 10.13, 1960 , and that death occurred at 10:08 PM , from the causes and on the date stated above | | | |
| 22a. SIGNATURE Stella Wachslar | | 22b. DATE SIGNED 10/13/60 | |
| 22c. PHYSICIAN'S NAME (Type) STELLA WACHSLER | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 10-17-1960 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE G. HOWARD STRONG BALTIMORE, MD. | | 25a. REC'D BY REGISTRAR DATE OCT 17 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |



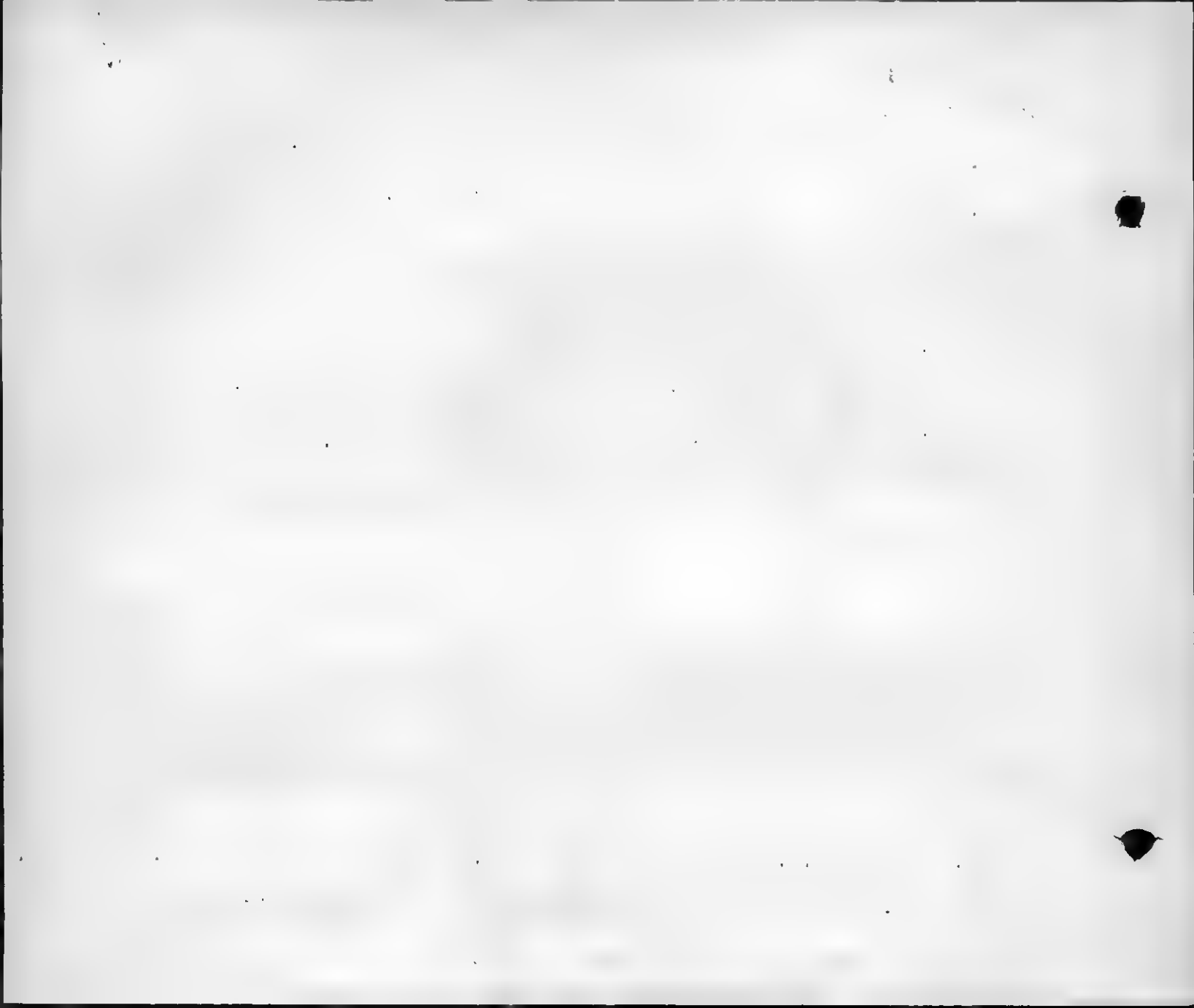
may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11149

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE City d. STREET ADDRESS 1915 W. LOMBARD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOSEPH First JAMES Middle O'HALLORAN Last | | | | 4. DATE OF DEATH Month 10 Day 26 Year 1960 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JAN. 8, 1912 | |
| 9. AGE (In years last birthday) 48 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOSEPH JAMES O'HALLORAN | | | | 14. MOTHER'S MAIDEN NAME KATHERINE Mc DONALD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 215-05-8992 | | 17. INFORMANT Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 years | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-20 1960 to 10-26 1960 , that (I) (we) last saw the deceased alive on Oct 26 1960 , and that death occurred at 9:45 A M, from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Wm. Newcomer | | | | 22b. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md. | | 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/29/60 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 23d. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan | | | | 25a. REC'D BY REGISTRAR OCT 27 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Frank | |



may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

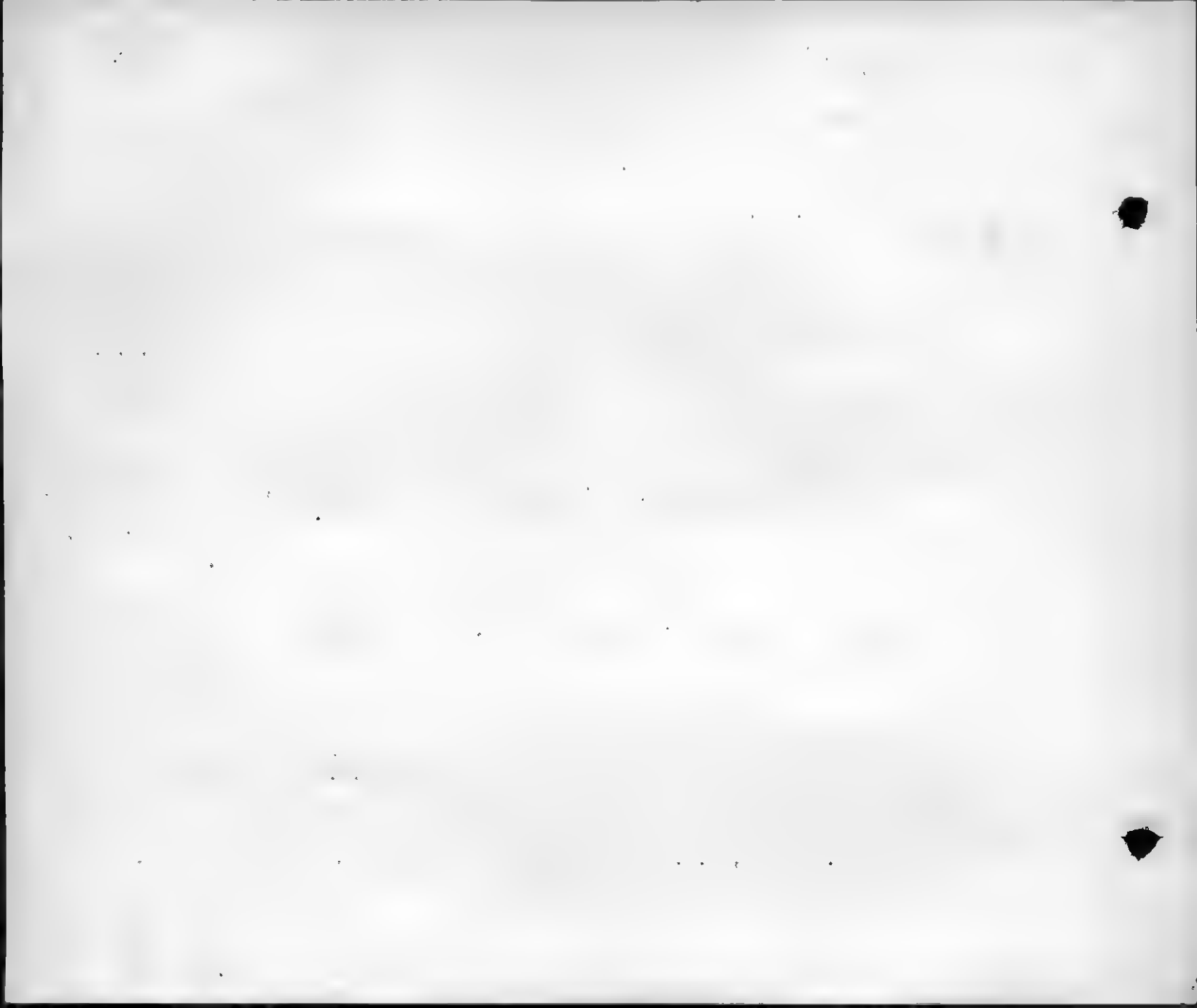
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11131

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|--|----------------------------------|---|-----------------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | | | c. LENGTH OF STAY IN 1b 2 mo. 2 da. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Tr. School | | | | d. STREET ADDRESS ----- | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 02X-2 | | | |
| 3. NAME OF DECEASED (Type or print) First Rosetta Middle Linda Last Parker | | | | 4. DATE OF DEATH Month 10 Day 31 Year 19 60 | | | |
| 5 SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/7/56 | | 9. AGE (In years last birthday) 42 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Leon Parker | | | | 14. MOTHER'S MAIDEN NAME Josephine Alice Downs, Lothian, Md. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Rosewood Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition; Decubitus ulcers of the scalp, left; 224X DUE TO diffuse bronchopneumonia bilaterally. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cranio pharyngioma with cyst producing obstructive DUE TO hydrocephalus, marked and systomatic epilepsy. (c) ----- | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months. 1 1/2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes insipidus not verified - 1 1/2 yrs. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/29 19 60 to 10/31 19 60 that (I) (we) last saw the deceased alive on 10/31 1960, and that death occurred at 6:50 p.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Harry G. Butler, M.D. | | | | 22b. DATE SIGNED 11/3/60 | | 22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D. | |
| 22d. ADDRESS Rosewood Lane, Owings Mills, Md. | | | | 22e. REC'D BY REGISTRAR Arthur L. Kraus | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF Nov. 6, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Int. Geo. | | 23d. LOCATION (City, town, or county) (State) Lothian Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John B. Johnson | | | | 25a. REC'D BY REGISTRAR NOV 9 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |



CERTIFICATE OF DEATH

11132

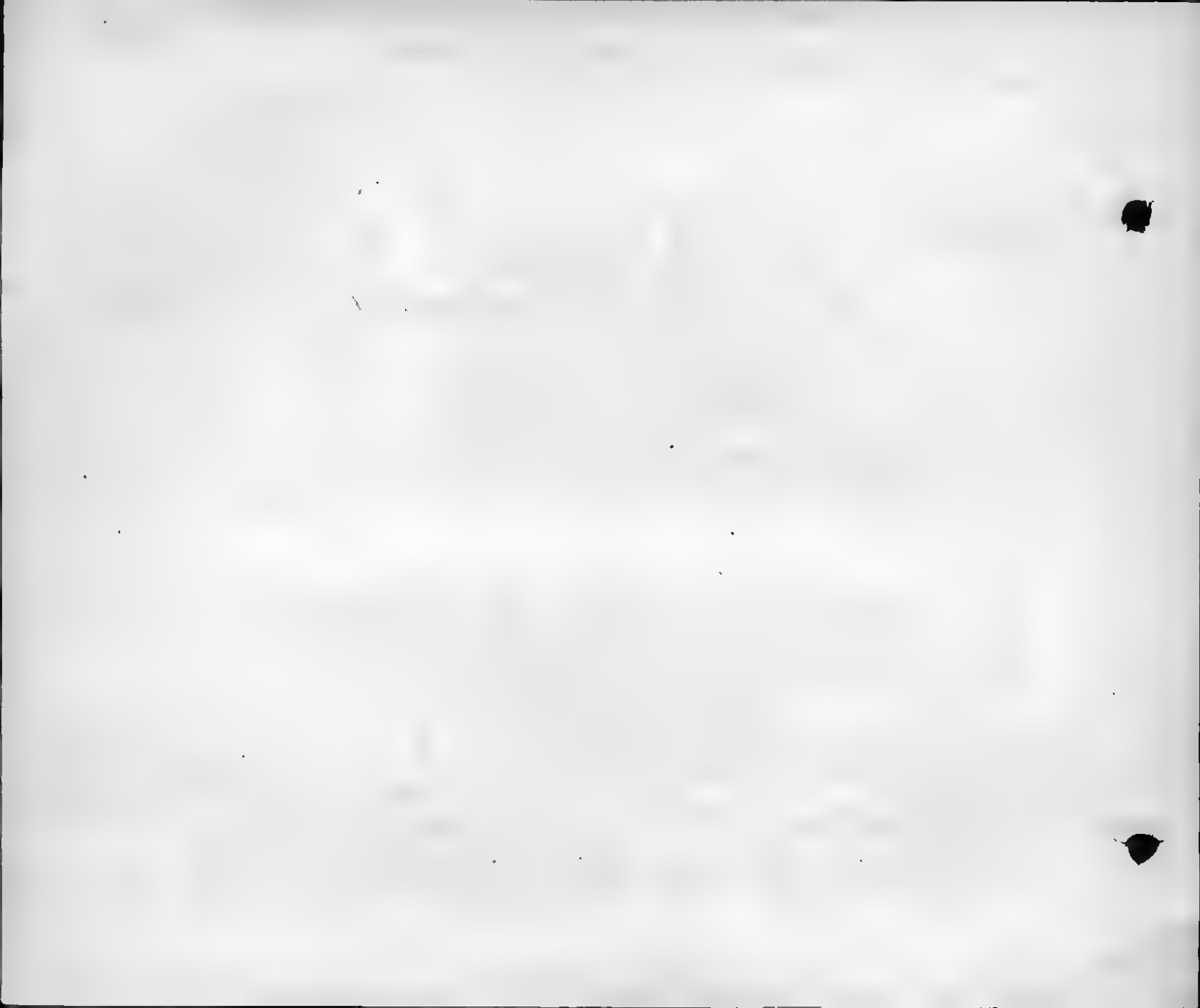
Reg. Dist. No.

11037

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|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admittance) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lundalk 22</u> | | c. LENGTH OF STAY IN lb <u>7 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8025 NORRIS LANE</u> | | d. STREET ADDRESS <u>18025 NORRIS LANE</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Otelia Payline Patterson</u> | | 4. DATE OF DEATH <u>October 1, 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>November 6, 1901</u> |
| 9. AGE (In years last birthday) <u>58</u> yrs | | IF UNDER 1 YEAR <u>10</u> Months <u>25</u> Days <u>18</u> Hours <u>19</u> Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Appomattox, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Willie D. Ferguson</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Goodridge</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>NONE</u> | |
| 17. INFORMANT <u>Earl Patterson</u> | | Address <u>8025 NORRIS LANE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> DUE TO <u>Myemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> (c) <u>Carcinoma of Colon</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>8 days</u> <u>24 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>AUGUST 25, 1958</u> to <u>OCTOBER 1, 1960</u> that I last saw the deceased alive on <u>OCTOBER 1, 1960</u> , and that death occurred at <u>4:10</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William C. Wade</u> | | DATE SIGNED <u>10/1/60</u> | |
| PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u> | | <u>Lundalk 22, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-4-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> | | ADDRESS <u>802 Madison Ave.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>OCT 5 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

11133

Reg. Dist. No.

11151

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines | | d. STREET ADDRESS 3404 Dolfield Avenue | |
| 3. NAME OF DECEASED (Type or print) First BESSIE Middle PAUL Last | | 4. DATE OF DEATH Month October Day 12 Year 1960 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1889 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS. Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Louis Goldman | |
| 14. MOTHER'S MAIDEN NAME Rachel ? | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Mr. Felix Paul- 3914 Fallstaff Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 193-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Ca of Lung (c) Ca of Brain (RT. side) | | | INTERVAL BETWEEN ONSET AND DEATH 1-20 hr. 62 hrs 73 hr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 10-20-1959 to 10-12-1960 , that I last saw the deceased alive on 10-22-1960 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore, Md. DATE SIGNED 10-12-60 | | | |
| ACTUAL SIGNATURE William K. Gallagher | | PHYSICIAN'S NAME (Type) William K. Gallagher | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct 16/60 | 22c. NAME OF CEMETERY OR CREMATORY Shaarei Tfiloh | 22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Road | | 24a. REC'D BY REGISTRAR DATE OCT 19 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

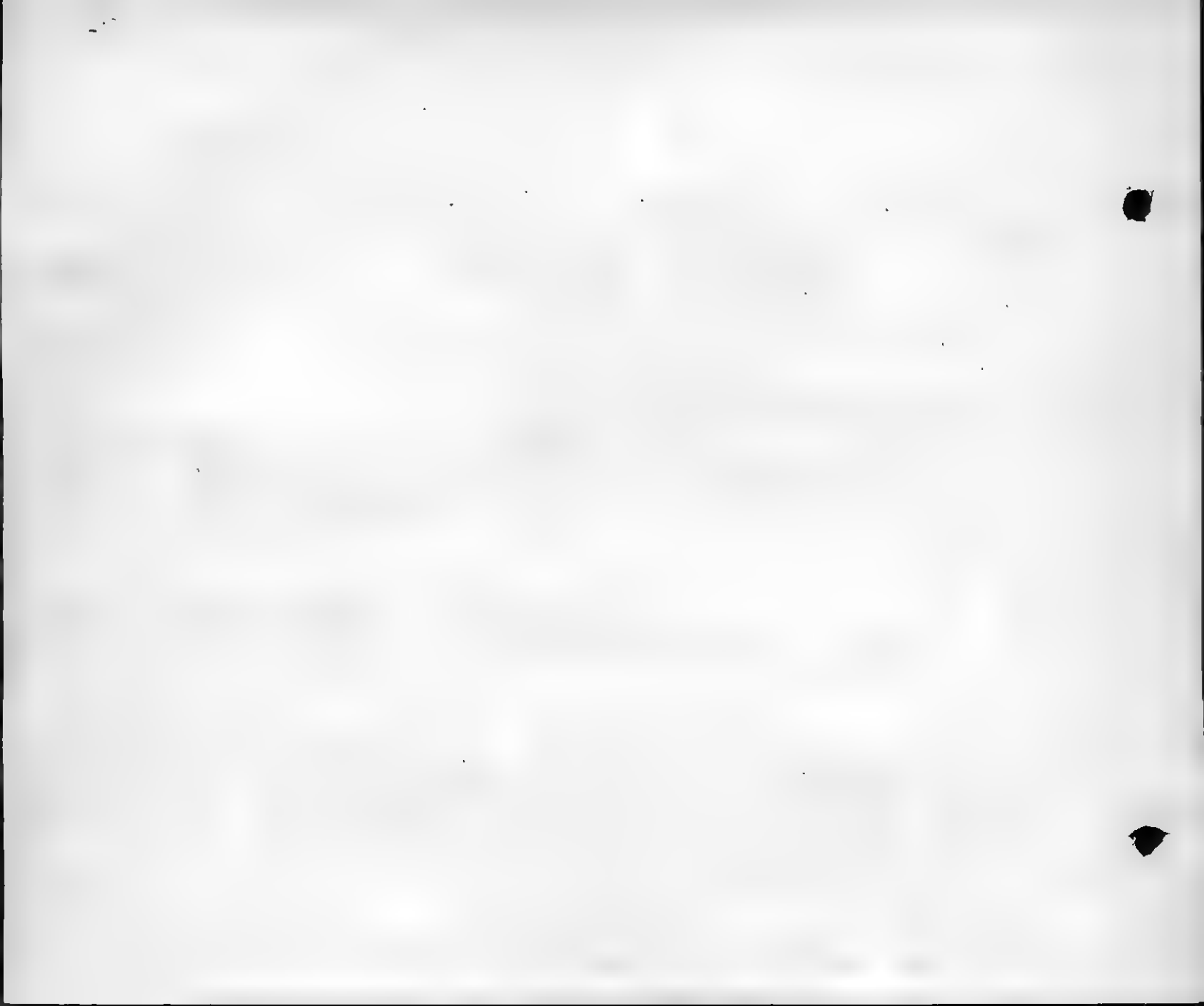


11152

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>SV 1 9</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN TB | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pine</u> | | d. STREET ADDRESS <u>3118 Oakfield Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>-</u> Last <u>Perkal</u> | | 4. DATE OF DEATH Month <u>10</u> - Day <u>6</u> - Year <u>1960</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday) <u>73</u> yrs | | IF UNDER 1 YEAR Months <u></u> Days <u></u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Peretz</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Hinda</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> | |
| 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>Moses Davis - 7309 Campfield Rd</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intermittent Cardiac Vasculitis</u> (b) <u>None</u> (c) <u>None</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from <u>Sept 30</u> , 19 <u>57</u> , to <u>October 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October 6</u> , 19 <u>60</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above | |
| ACTUAL SIGNATURE <u>Manuel Levin</u> M.D. <u>4/8/8 Keeler Rd</u> | | DATE SIGNED <u>10/8/60</u> | |
| PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, M.D.</u> | | <u>Baltimore - 15 MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-9-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Beth Tefeloh</u> | | 22d. LOCATION (City, town, or county) <u>Balto</u> (State) <u>Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u> ADDRESS <u>2100 Eutan Place</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 10 1960</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | | | |



11153

CERTIFICATE OF DEATH

11135
Reg. Dist. No.

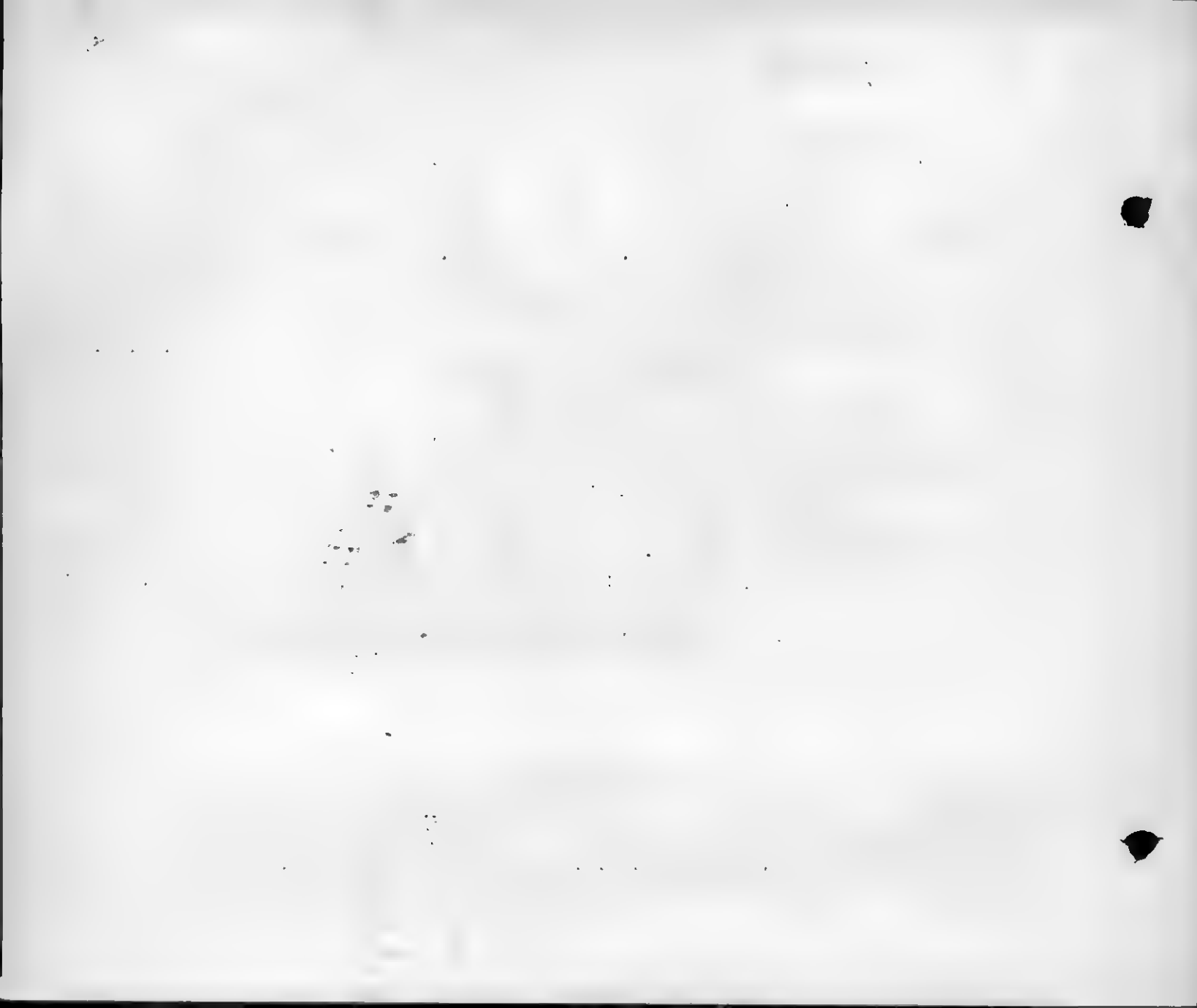
| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | c. LENGTH OF STAY IN 1b <u>Lifetime</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women & Mens Home</u> | | | | d. STREET ADDRESS <u>504 Delaware Ave 1</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Florence</u> | | | | 4. DATE OF DEATH <u>October 30 1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec 7- 1873</u> | |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u> Hours <u></u> Min <u></u> | | IF UNDER 24 HRS. Hours <u></u> Min <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Towson, Md.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>James Phipps</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Hiple</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u></u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bowel</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>October 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October 30</u> , 19 <u>60</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>4-E-33rd St Baltimore Md</u> | | | | | | | |
| DATE SIGNED <u>October 31, 1960</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Frederick Edward Day</u> | | | | M.D. <u>4-E-33rd St Baltimore Md</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>11-2-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Govans Presbyterian Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Govans, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> | | | | 24a. REC'D BY REGISTRAR <u>NOV 1 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | | | b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland | | | | c. LENGTH OF STAY IN 1b 20 Days | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 6806 Falt Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) FRANK F. PIECHOCKI | | | | 4. DATE OF DEATH Month October Day 4 Year 1960 | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 29, 1896 | | 9. AGE (In years lost birthday) yrs 64 | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Company | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Martin Piechocki | | | | 14. MOTHER'S MAIDEN NAME Mary Novak | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I | | 17. INFORMANT WW I | | Address 213-09-2502 Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT LUNG 1-2-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATELECTASIS, LEFT LUNG (c) EMPHYSEMA, BOTH LUNGS METASTATIC CARCINOMA, OMENTUM, LIVER, LEFT 4TH RIB | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED. EMACIATION. | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 14 1960 to Oct. 4 1960 , that (I) (we) last saw the deceased alive on Oct. 4 1960 , and that death occurred at 8:45 M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Frederick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 10/4/60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 10-8-60 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Walter Dabrowski, 1001-A Dundalk Ave., Balto. 22, Md. | | | | | | 25a. REC'D BY REGISTRAR OCT 7 '60 | | 25b. REGISTRAR'S SIGNATURE Walter Dabrowski | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11137**

11155

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b 51 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 517 Overbrook Road | | | | d. STREET ADDRESS 1517 Overbrook Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle J. Last PRICE | | | | 4. DATE OF DEATH Month Oct. Day 26 , Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 11, 1898 | | 9. AGE (in years last birthday) 61 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive | | 10b. KIND OF BUSINESS OR INDUSTRY Wiping Cloth Maker | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Michael Price | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 217-32-8971 | | 17. INFORMANT Address Myrtle K. Price - 517 Overbrook Rd, 12 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Insufficiency DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden 2 spot | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 10/27/60 | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/31/60 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. | | | | ADDRESS 1050 York Rd. Towson | | 24a. REC'D BY REGISTRAR Oct 31 1960 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles F. O'Donnell | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



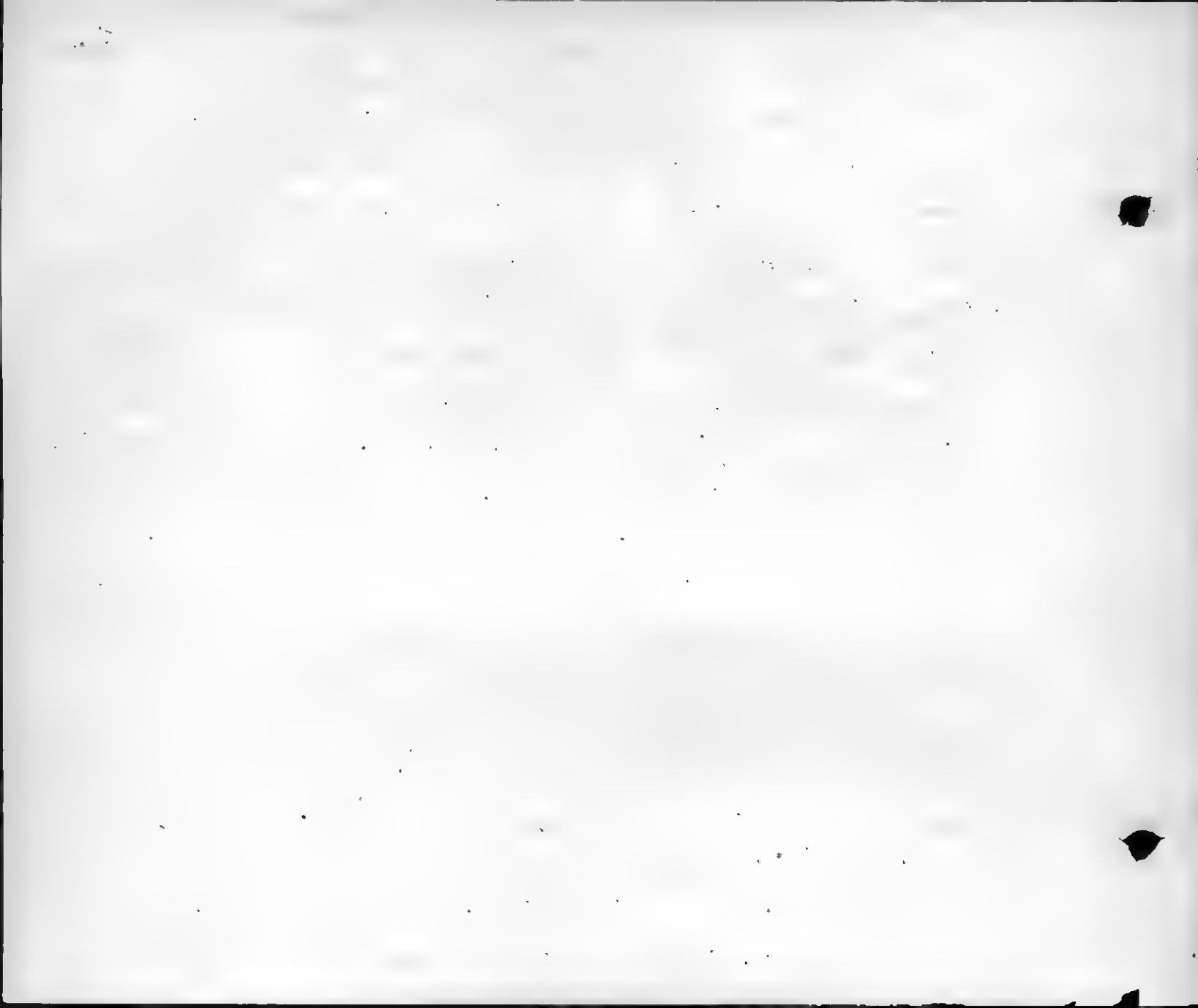
CERTIFICATE OF DEATH

Reg. Dist. No.

11156

11138

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN ARM, MD. | | c. LENGTH OF STAY IN 1b LIFE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 31, GLEN ARM. | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle M. Last PRIGEL | | 4. DATE OF DEATH Month OCT Day 5 Year 1960 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN 21, 1873 |
| 9. AGE (In years last birthday) 87 yrs | | 10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: Months _____ Days _____ Hours _____ Min _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMER | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME MATTHEW PRIGEL | | 14. MOTHER'S MAIDEN NAME UNKNOWN. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 120-34-6179 | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 3321 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerosis DUE TO (c) Obstructed Kidney | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks year unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 1960 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 6 , 19 60 , to Dec 5 , 19 60 , that I last saw the deceased alive on Dec 6 , 19 60 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Balchwin DATE SIGNED ACTUAL SIGNATURE Walter M. Hammett PHYSICIAN'S NAME (Type) Walter M. Hammett | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF OCT 8, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY CHURCH OF THE BRETHREN | | 22d. LOCATION (City, town, or county) (State) LONG GREEN MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jessie L. Funeral Home | | 24a. REC'D BY REGISTRAR DATE OCT 10 '60 | |
| ADDRESS 17401 Belair Rd. #6 | | 24b. REGISTRAR'S SIGNATURE Jessie L. Funeral Home | |



CERTIFICATE OF DEATH

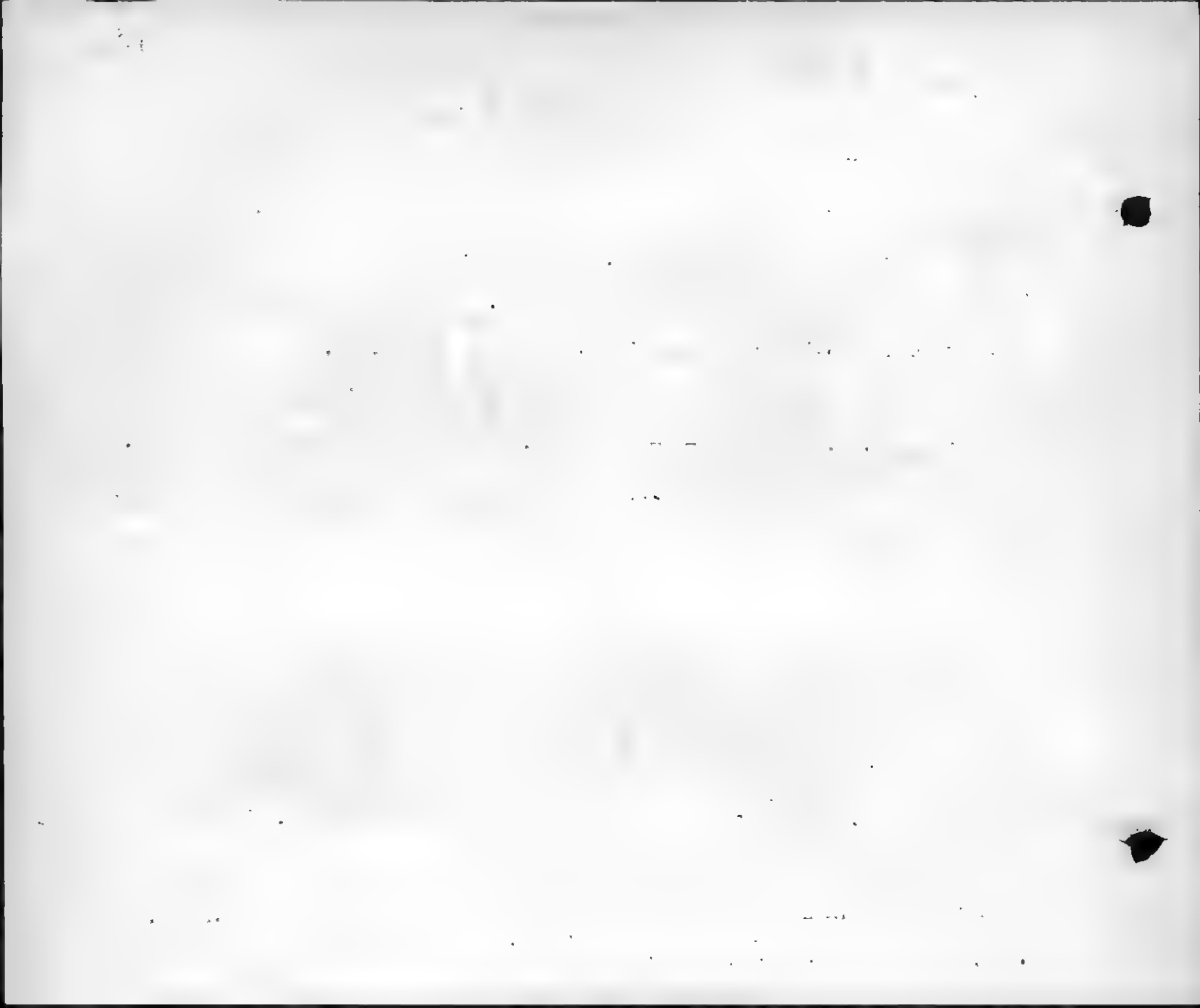
Reg. Dist. No. 11139

11157

| | | | | | | | |
|--|----------------------------------|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loch Raven</u> | | | | c. LENGTH OF STAY IN 1b <u>Loch Raven</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cromwell Bridge Rd.</u> | | | | e. STREET ADDRESS <u>Cromwell Bridge Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T.</u> Last <u>Prime</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>19 60</u> | | | |
| 5 SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 4, 1907</u> | 9. AGE (In years last birthday) yrs <u>53</u> | IF UNDER 1 YEAR Months <u>53</u> Days <u></u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Prime</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sally O'Donell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO <u>W. W. # 2 211-01-1659</u> | | 17. INFORMANT Address <u>Mrs. Stella Prime Cromwell Bridge Rd. 34</u> | | | |
| 18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>103</u> IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Approx 8 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Oct 31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>60</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Victor Francis King</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1103 E. Joppa Rd.</u> | | DATE SIGNED <u>10/31/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Victor Francis King</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-2-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home</u> | | | | ADDRESS <u>7401 Belair Rd.</u> | | 24a. REC'D BY REGISTRAR DATE <u>NOV 2 '60</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraso</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

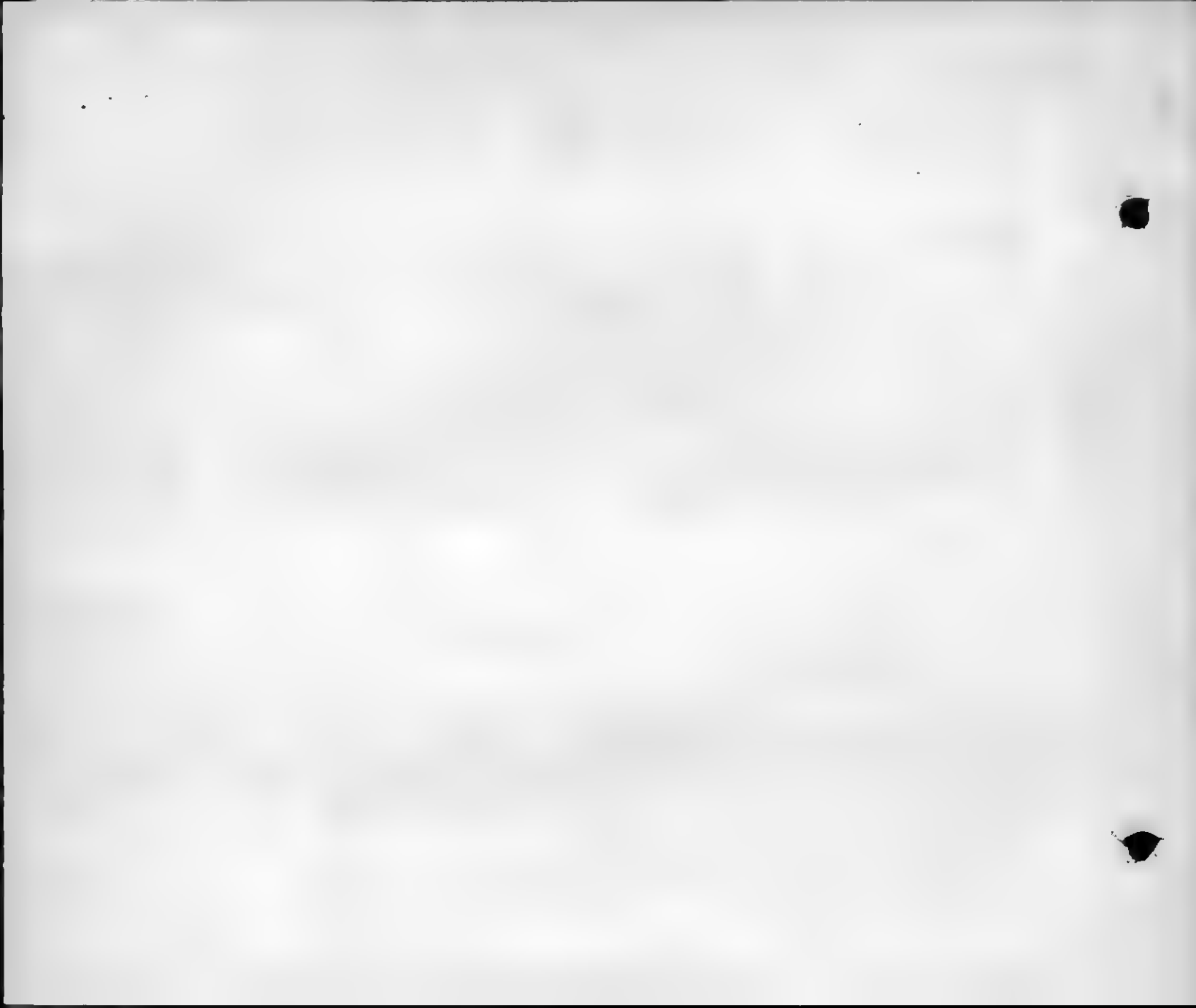
11158

CERTIFICATE OF DEATH

11140
Reg. Dist. No.

| | | | |
|--|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Lane</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Pumphrey</u> | | 4. DATE OF DEATH Month Day Year <u>Oct. 7 1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 28 1879</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>A.A. Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Steven T. Rodgers</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Rodmiles</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>XXXX-XX-XXXX</u> | |
| 17. INFORMANT Address <u>XXXX-XX-XXXX</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>334X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> <u>Myocardial Insufficiency</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 1956</u> to <u>Oct. 1960</u> , that I last saw the deceased alive on <u>Oct. 7 1960</u> , and that death occurred at <u>945</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>10-7-60</u> | | | |
| ACTUAL SIGNATURE <u>William W. Tyson</u> M.D. | | PHYSICIAN'S NAME (Type) <u>William W. Tyson</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11th Oct-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 10 1960</u> | |
| ADDRESS <u>Glen Burnie, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>William W. Tyson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

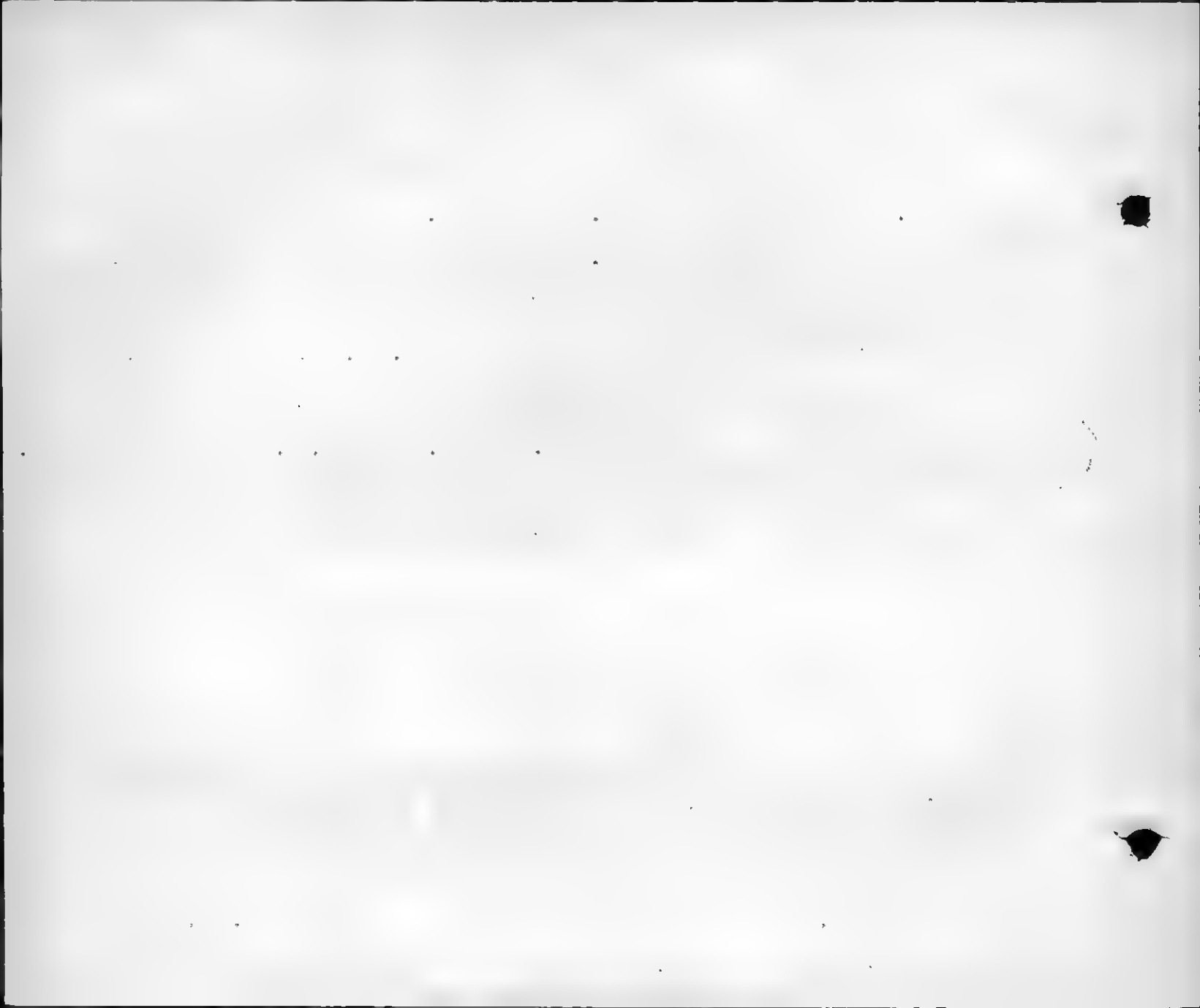
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111151

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11141

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville | | c. LENGTH OF STAY IN 1b X | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1 Box 389 Kingsville, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Edward Middle A. Last Quick | | 4. DATE OF DEATH Month October Day 16 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 3, 1865 |
| 9. AGE (In years lost birthday) 95 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Peter Quick | | 14. MOTHER'S MAIDEN NAME Barbara Seifert | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mr. Harry G. Quick Rt. 1. Box 389 Kingsville Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 13, 1960 to Oct 16, 1960 , that (I) was lost saw the deceased alive on Oct 16, 1960 , and that death occurred at 12:15 P , from the causes and on the date stated above | | | |
| 22a. SIGNATURE Fred O. Hodous | | 22b. DATE SIGNED 10-17-60 | |
| 22c. PHYSICIAN'S NAME (Type) Fred O. Hodous | | 22d. ADDRESS Edgewood Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 19, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mountain Christian | | 23d. LOCATION (City, town, or county) (State) Harford Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Carroll Funeral Home | | 25a. REC'D BY REGISTRAR DATE OCT 18 '60 | |
| ADDRESS 7401 Belair Rd | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



11160

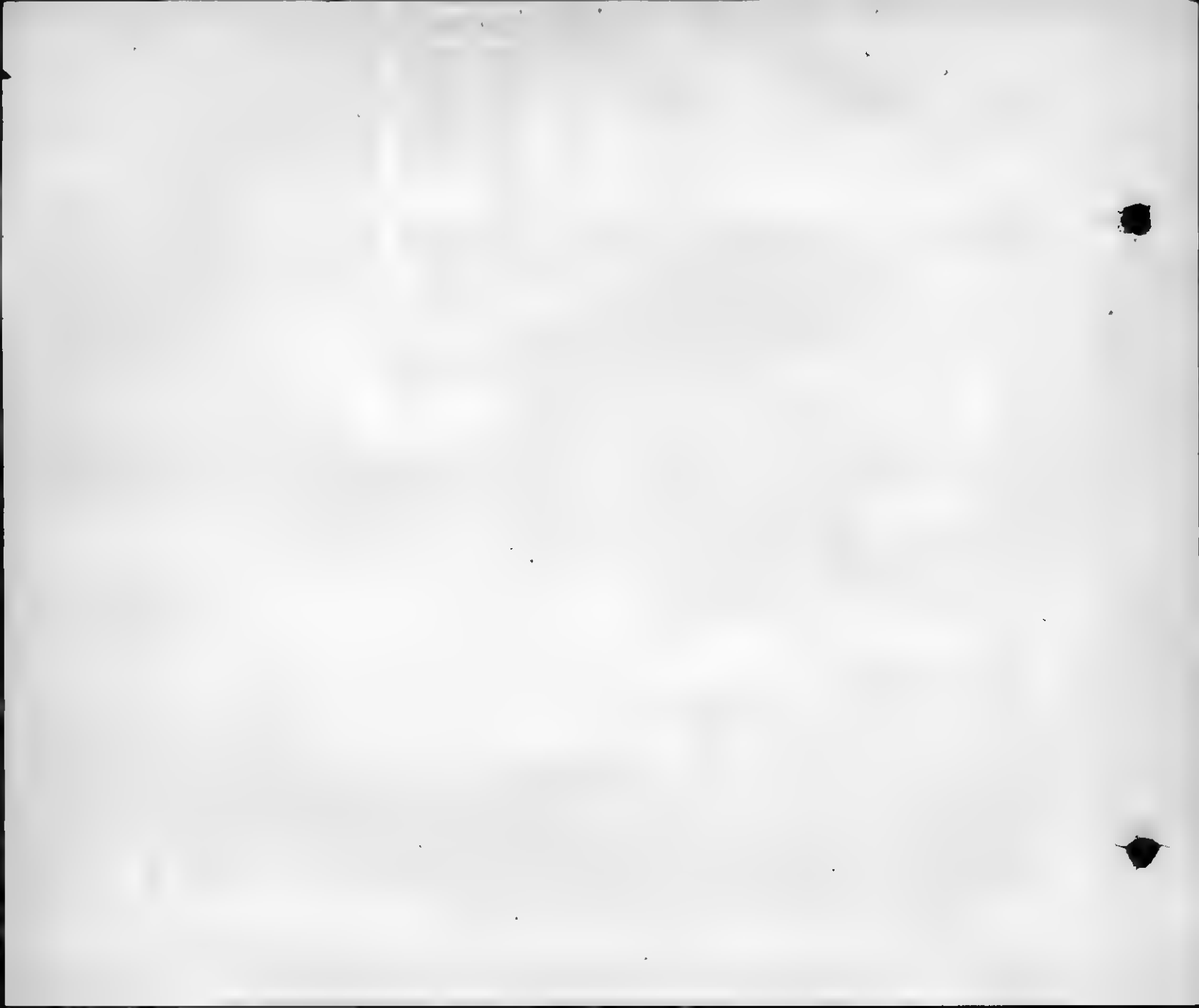
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Sumner Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore City</u> b. COUNTY <u>Baltimore City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md</u> | | | | c. LENGTH OF STAY IN 1b <u>3 Weeks</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>I907 Griffiss Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Patrick F. Reedy</u> | | | | 4. DATE OF DEATH Month <u>10-12</u> Day <u>1980</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-28-1871 ?</u> | |
| 9. AGE (In years last birthday) <u>89 ?</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Brass Machine CO</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Michael Reedy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>U S A</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>---</u> | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>215-05-1253</u> | | 17. INFORMANT <u>Bernard J Mory 200I Harman Ave Balto 30 Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerosis Obliterans</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>with Developing Gangrene Rt Foot</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputation Mid thigh left old</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/22/60</u> to <u>10/12/60</u> , that I last saw the deceased alive on <u>10/11/60</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W E McGraw</u> | | | | ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28 Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W E McGraw</u> | | | | DATE SIGNED <u>10/13/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-15-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson 2359 Wash Balto Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 17 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

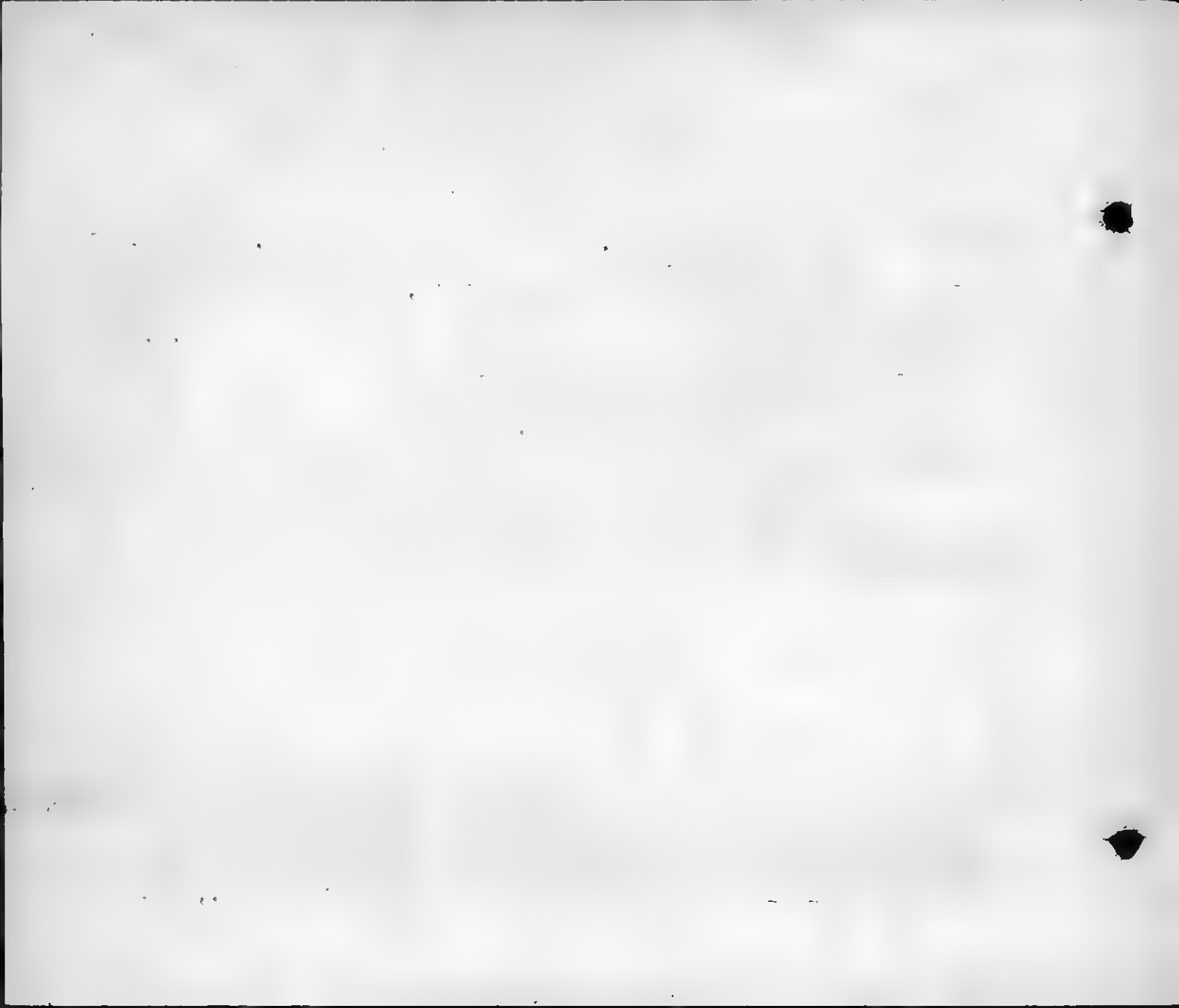
11161

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11143
Reg. Dist. No. 3298

| | | | | | | | |
|--|------------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 Winters Lane | | | | d. STREET ADDRESS 44 Winters Lane | | | |
| 3. NAME OF DECEASED (Type or print) First ASBURY Middle C. Last RIDEOUT | | | | 4. DATE OF DEATH Month Oct. Day 27 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 14, 1902 | 9. AGE (In years last birthday) 58 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Rideout | | | | 14. MOTHER'S MAIDEN NAME Lillian Cook | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Violet Rideout 44 Winters Lane Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Emphysema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 11-17-1954 to 10-27-1960 that I last saw the deceased alive on 10-27-1960 and that death occurred at 4:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1029 N. Stricker St Baltimore Md. DATE SIGNED 10-28-60 | | | | | | | |
| ACTUAL SIGNATURE Frank A. Saunders M.D. | | | | DATE SIGNED 10-28-60 | | | |
| PHYSICIAN'S NAME (Type) FRANK A. SAUNDERS MD | | | | Baltimore Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-30-60 | | 22c. NAME OF CEMETERY OR CREMATORY Western Star | | 22d. LOCATION (City, town, or county) (State) Baltimore Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE (Mrs) Frances A. Hemsley | | | | ADDRESS 578 W. Biddle St. | | 24a. REC'D BY REGISTRAR DATE NOV 1 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hensley | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11162

CERTIFICATE OF DEATH

11144

Reg. Dist. No.

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last RUTH HOPE ROBINSON | | 4. DATE OF DEATH Month Day Year Oct. 29, 1960 | |
| 5. SEX F. | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 20, 1893 |
| 9. AGE (In years last birthday) yrs. 67 | | 10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady | | 10b. KIND OF BUSINESS OR INDUSTRY Dept. Store | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Abel Durham | | 14. MOTHER'S MAIDEN NAME Ella Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213-20-2790 | |
| 17. INFORMANT Mrs. Virginia R. Hunt | | Address Timonium, Md. 1341 Locust Ridge Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with generalized metastases</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH 1-4 1/2 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 1, 1960, to Oct 29, 1960, that I last saw the deceased alive on Oct 28, 1960, and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town/state) DATE SIGNED Luther W. McMichael, M.D. Oct 31, 1960 | | | |
| ACTUAL SIGNATURE Luther W. McMichael, M.D. | | PHYSICIAN'S NAME (Type) Luther W. McMichael | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 1, '60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jm. Cook-Townson, Inc. | | ADDRESS 1050 York Rd. | |
| 24a. REC'D BY REGISTRAR DATE NOV 1 '60 | | 24b. REGISTRAR'S SIGNATURE Carlton S. House | |

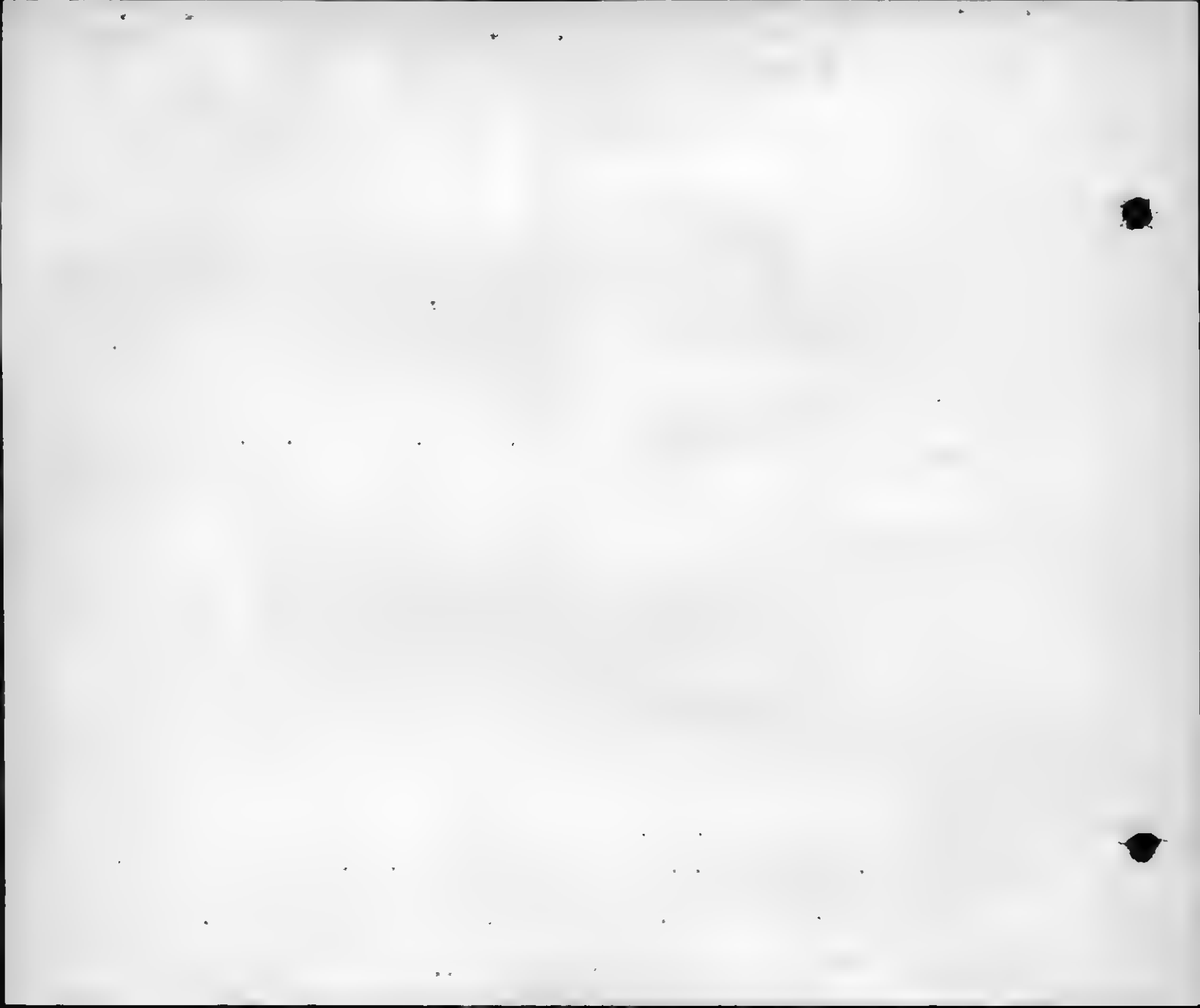


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11163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11145

| | | | |
|--|-------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 15 minutes d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harward c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage d. STREET ADDRESS 513 Baltimore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOSEPH Middle ROHOL Last ROHOL | | 4. DATE OF DEATH Month OCTOBER Day 13 Year 1960 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 28, 1917 |
| 9. AGE (In years last birthday) 43 yrs | | 10. IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min. 43 | 11. IF UNDER 24 HRS Months 43 Days 43 Hours 43 Min. 43 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckers Helper | | 10b. KIND OF BUSINESS OR INDUSTRY Distillery | 11. BIRTHPLACE (State or foreign country) Gates, Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Peter Rohol | |
| 14. MOTHER'S MAIDEN NAME Anna (Last Name Unknown) | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II | |
| 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT CLIN. RECORDS. VAH, BALTO. MD. FT HOWARD DIVISION | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 ACUTE MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) 420.1 | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from October 13, 1960 to October 13, 1960 , that (I) (we) lost the deceased alive on October 13, 1960 , and that death occurred on October 13, 1960 from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Paul G. Koukoulas | | 22b. DATE SIGNED 10/13/60 | |
| 22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS, M.D. | | 22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10/17/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION (City, town, or county) (State) Bladensburg, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE DONALDSON FUNERAL HOME, TALBOTT STREET, LAUREL, MD | | 25a. REC'D BY REG STRAR OCT 19 '60 | |
| 25b. REGISTRAR'S SIGNATURE Charles P. Hume | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

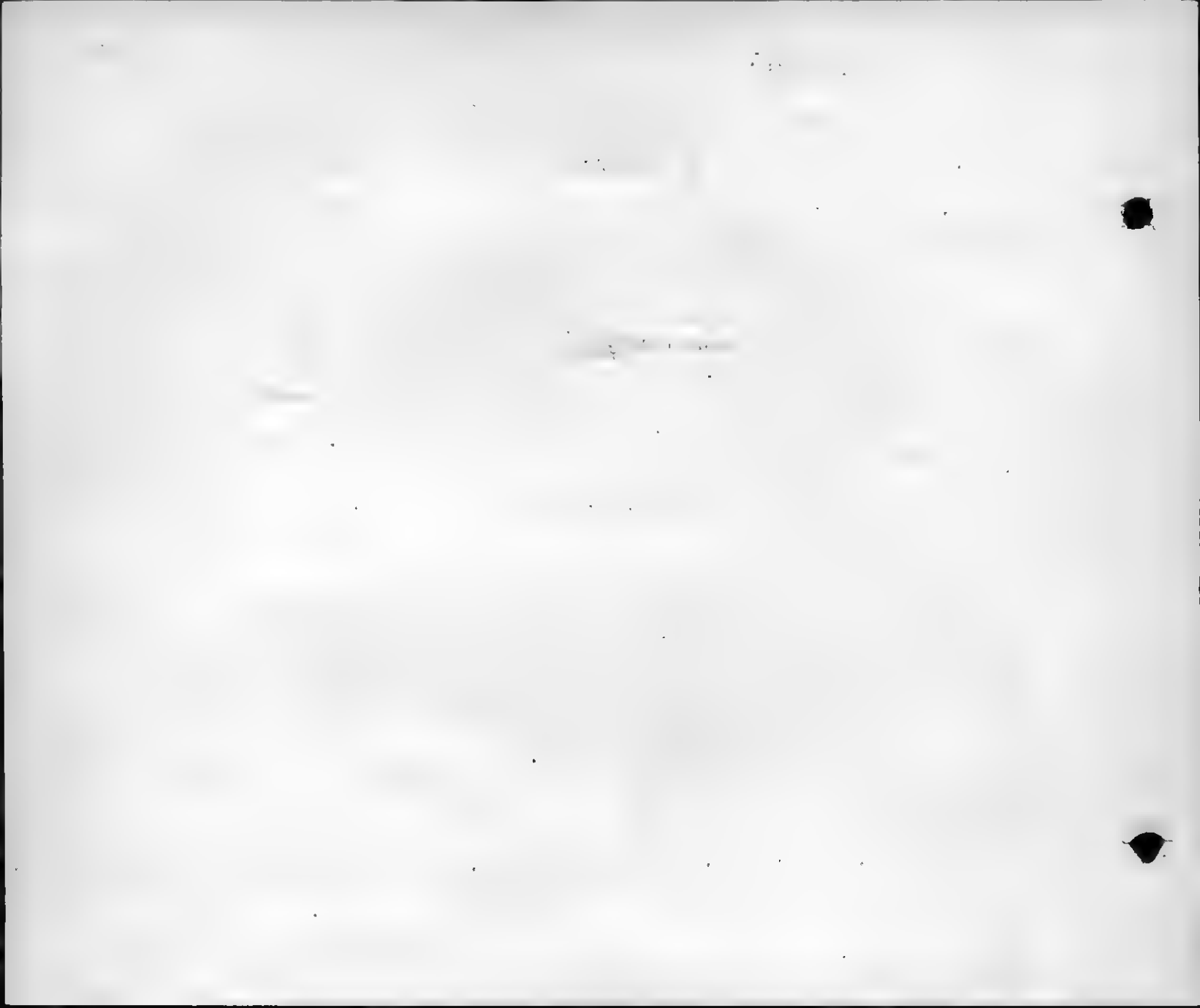
VR ATS (4)
ISM 9/59

11164

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11146

| | | | |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u> | | c. LENGTH OF STAY IN 1b <u>2 months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Mt. Wilson State Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Frank</u> Last <u>Sauers</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>11-7-1901</u> |
| 9. AGE (In years last birthday) <u>58</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>1</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>JOHN HOPKINS SCHOOL</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland, Balto.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William F. Sauers</u> | | 14. MOTHER'S MAIDEN NAME <u>Olive Collins</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> or unknown) | | 16. SOCIAL SECURITY NO. <u>✓</u> | |
| 17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis and</u> DUE TO <u>Empyema.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-3-1960</u> to <u>10-1-1960</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-1-1960</u> , and that death occurred at <u>1038</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Wm. Newcomer</u> | | 22b. DATE SIGNED <u>10-1-60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u> | | 22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/5/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u> | | 23d. LOCATION (City, town, or county) _____ (State) _____ | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kraus</u> | | 25a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | | | |



11165

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11147

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3700 Villa Nova Ave. | | d. STREET ADDRESS 3309 Dorchester Rd. | |
| 3. NAME OF DECEASED (Type or print) DAVID SAVADOW | | 4. DATE OF DEATH October 13 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 26, 1886 |
| 9. AGE (In years last birthday) 74 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manuf | | 10b. KIND OF BUSINESS OR INDUSTRY Barfel | |
| 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Victor Savadow | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-34-8563 | |
| 17. INFORMANT Mrs. Muriel S. Schleider-- Same | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO A.S.C.U.D. (c) | | INTERVAL BETWEEN ONSET AND DEATH MINUTE 1 MONTH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 8 1960 to Oct 13 1960 , that (I) (we) last saw the deceased alive on Oct 12 1960 , and that death occurred at 1 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph Shear MD | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOSEPH SHEAR MD | | 22d. ADDRESS 4413 1/2 PARK HEIGHT AVE BALD 15 | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/16/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh Cong. | | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | 25a. REC'D BY REGISTRAR | |
| ADDRESS | | DATE OCT 19 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

S OL LEVINSON & BROS INC, 6010 Reisterstown Rd.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11166
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11148
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1
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 16 Box 508 | | d. STREET ADDRESS Rt. 16 Box 508 | | | | | |
| 3. NAME OF DECEASED (Type or print) George | | First | | Middle | | Last | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF DEATH October 18, 19 60 | |
| 9. AGE (In years last birthday) 84 | | 10. DATE OF BIRTH May 19, 1876 | | 11. AGE (In years last birthday) 84 | | 12. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Sawyer | | 14. MOTHER'S MAIDEN NAME Mary Ann Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Mrs. Martha J. Sawyer Rt. 16 Box 508 (20) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIO-SCLEROSIS DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 MO. 8 YRS | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS A J. APTOSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from MAY 28 1952 to OCT 18 1960, that (I) (we) last saw the deceased alive on OCT 13 1960, and that death occurred at 2:20 A.M. from the causes and on the date stated above | | 22a. SIGNATURE Joseph Miceli M.D. | | 22b. DATE SIGNED 10/19/60 | | 22c. PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D. | |
| 23a. BJR AL. CREMAT ON REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 21, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist | | 23d. LOCATION (City, town, or county) (State) Chase, Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home | | ADDRESS 7401 Belair Rd. | | 25a. REC'D BY REGISTRAR OCT 20 '60 | | 25b. REGISTRAR'S SIGNATURE C. L. H. H. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11167

CERTIFICATE OF DEATH

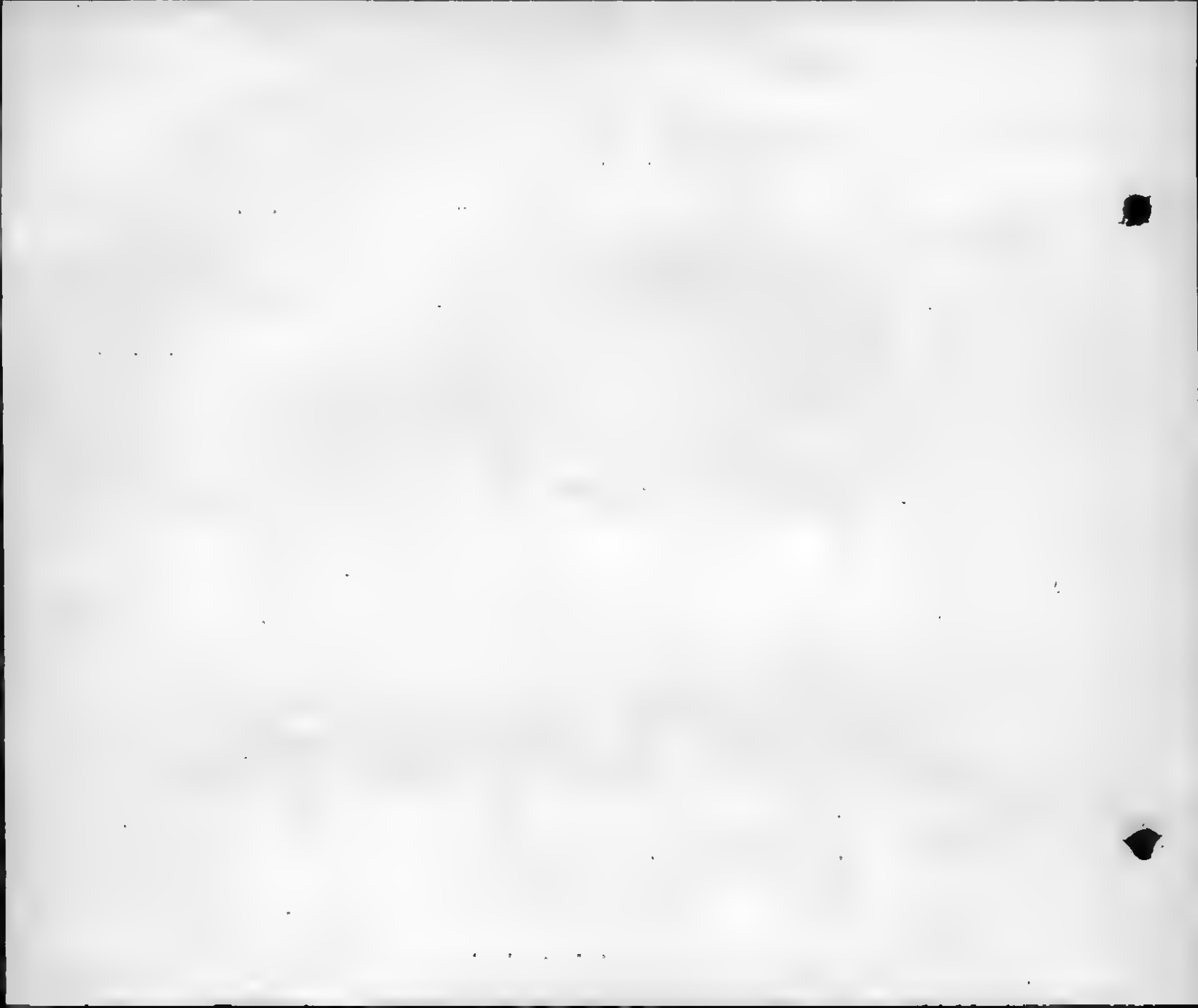
11149

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|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b 2Yrs. 1Mo. 20Das. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital | | | | e. STREET ADDRESS 1530 - 30th Street, N. W. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First May Middle Somerville Last Schell | | | | 4. DATE OF DEATH Month October Day 31 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 21, 1865 | |
| 9. AGE (In years last birthday) 95 yrs. | | IF UNDER 1 YEAR Months 95 Days 95 Hours 95 Min 95 | | IF UNDER 24 HRS. Months 95 Days 95 Hours 95 Min 95 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Canada | | | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME John Somerville | | | | 14. MOTHER'S MAIDEN NAME Elizabeth McKinnon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Hospital Records | | | |
| 17. INFORMANT Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Chronic myocarditis DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome; Senile Brain Disease INTERVAL BETWEEN ONSET AND DEATH 4 da 6 yr - 7 11 | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 11 19 58 to Oct 31 19 60 , that (I) (we) last saw the deceased alive on Oct 29 19 60 and that death occurred at 8:30 P from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE W.W. Elgin | | | | 22b. DATE SIGNED November 1, 1960 | | | |
| 22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M. D. | | | | 22d. ADDRESS The Sheppard and Enoch Pratt Hospital Towson, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | | | 23b. DATE THEREOF 11/2/60 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | | | 23d. LOCATION (City, town, or county) (State) Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph F. BIRCH'SONS | | | | 25a. REC'D BY REGISTRAR NOV 3 '60 | | | |
| ADDRESS 3034 M St. N.W., D. C. | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | |

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11168

CERTIFICATE OF DEATH

11150

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>533 Dale Avenue</u> | | d. STREET ADDRESS <u>533 Dale Avenue</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Mary Anna Schlicht</u> | | 4. DATE OF DEATH Month Day Year <u>October 6th 19 60</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 23, 1893</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Mossberger</u> | | 14. MOTHER'S MAIDEN NAME <u>Eva ?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Address <u>Mr. Joseph M. Schlicht 533 Dale Ave #6</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lymph nodes</u> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>3 m</u> <u>18 m</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>54</u> , to <u>10-4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-4</u> , 19 <u>60</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Santi Amoroso</u> M.D. <u>501 Bessie Rd Baltimore 6, Md</u> | | DATE SIGNED <u>10-6-60</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10/10/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11169

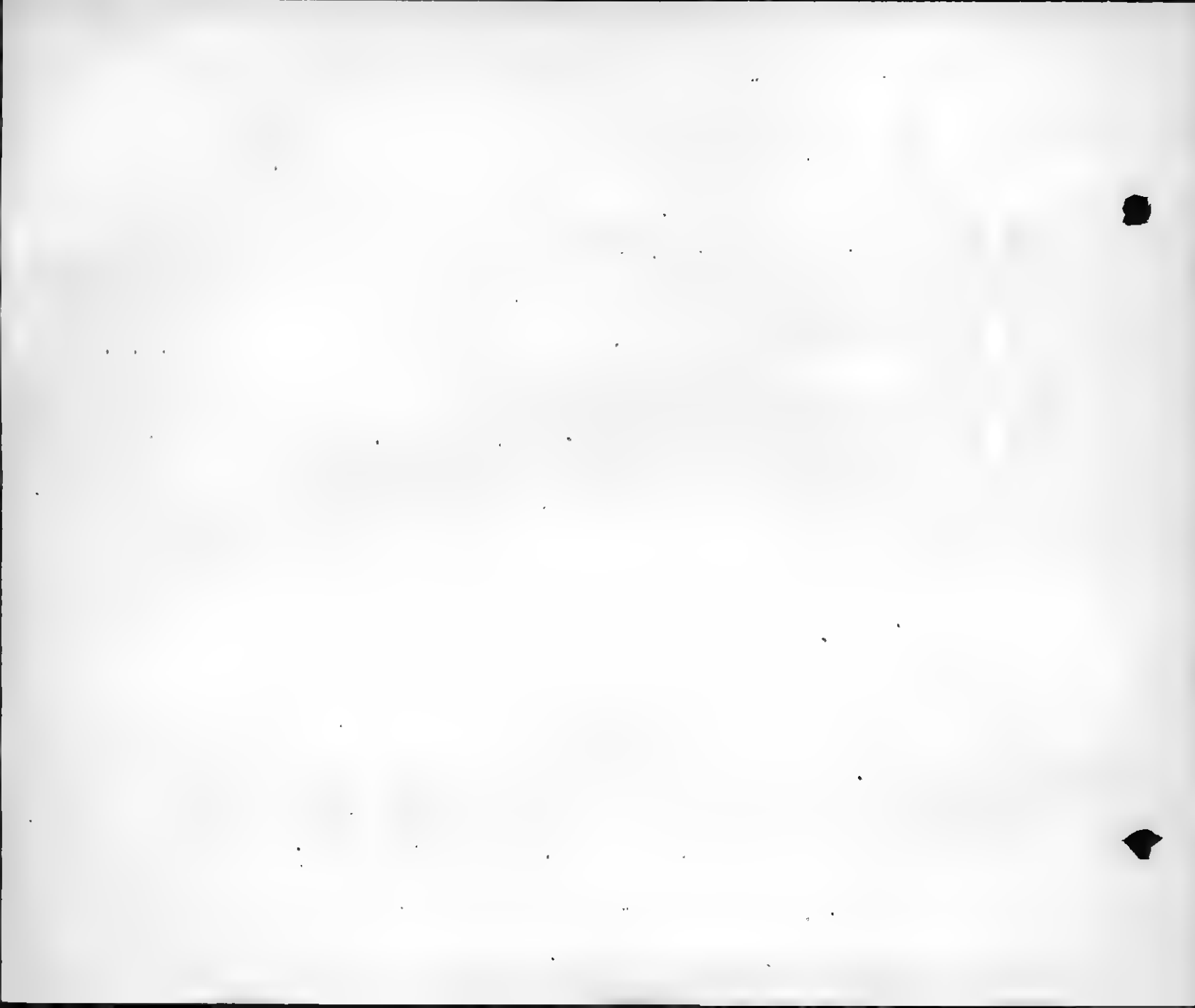
CERTIFICATE OF DEATH

Reg. Dist. No. 11151

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u> | | c. LENGTH OF STAY IN 1b <u>Lifetime</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Linden Terrace</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen Gertrude Seibold</u> | | 4. DATE OF DEATH Month Day Year <u>Oct 24, 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 15, 1880</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 11 BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Thomas Fairley</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Rose Gettier</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>1942-1945</u> | |
| 16 SOCIAL SECURITY NO. <u>216-09-207</u> | | INFORMANT <u>Mrs. Mary Louise Feustle, 11 Linden Terrace</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Several yrs</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis generalized</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June, 1960</u> to <u>24 Oct, 1960</u> , that I last saw the deceased alive on <u>21 Oct, 1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Paul Royse</u> M.D. | | ADDRESS (Street, city or town, state) <u>1403 Foley Lane Pikesville 8, Md.</u> DATE SIGNED <u>10/26/60</u> | |
| PHYSICIAN'S NAME (Type) <u>PAUL H. ROYSE, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct. 27, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> ADDRESS <u>Pikesville 8, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE OCT 28 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Form G-273 10-20-60 et

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4410 Calverton Ave</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | |
| 3. NAME OF <u>EDWARD GRAY</u> (Type or print) First Middle Last | | 4. DATE OF DEATH <u>Oct</u> Month <u>21</u> Day <u>1960</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 21, 1904</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired State Employee State of Md</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George W. Sensibaugh</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel Potter</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> | | 16. SOCIAL SECURITY NO <u>None</u> | |
| 17. INFORMANT <u>O. Howard Sensibaugh</u> | | Address <u>711 Hammond Ferry Rd</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arterio sclerotic cardiovascular disease</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-25-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Frank</u> | | ADDRESS <u>Baltimore, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>Oct 24 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u> | |

MEDICAL CERTIFICATION

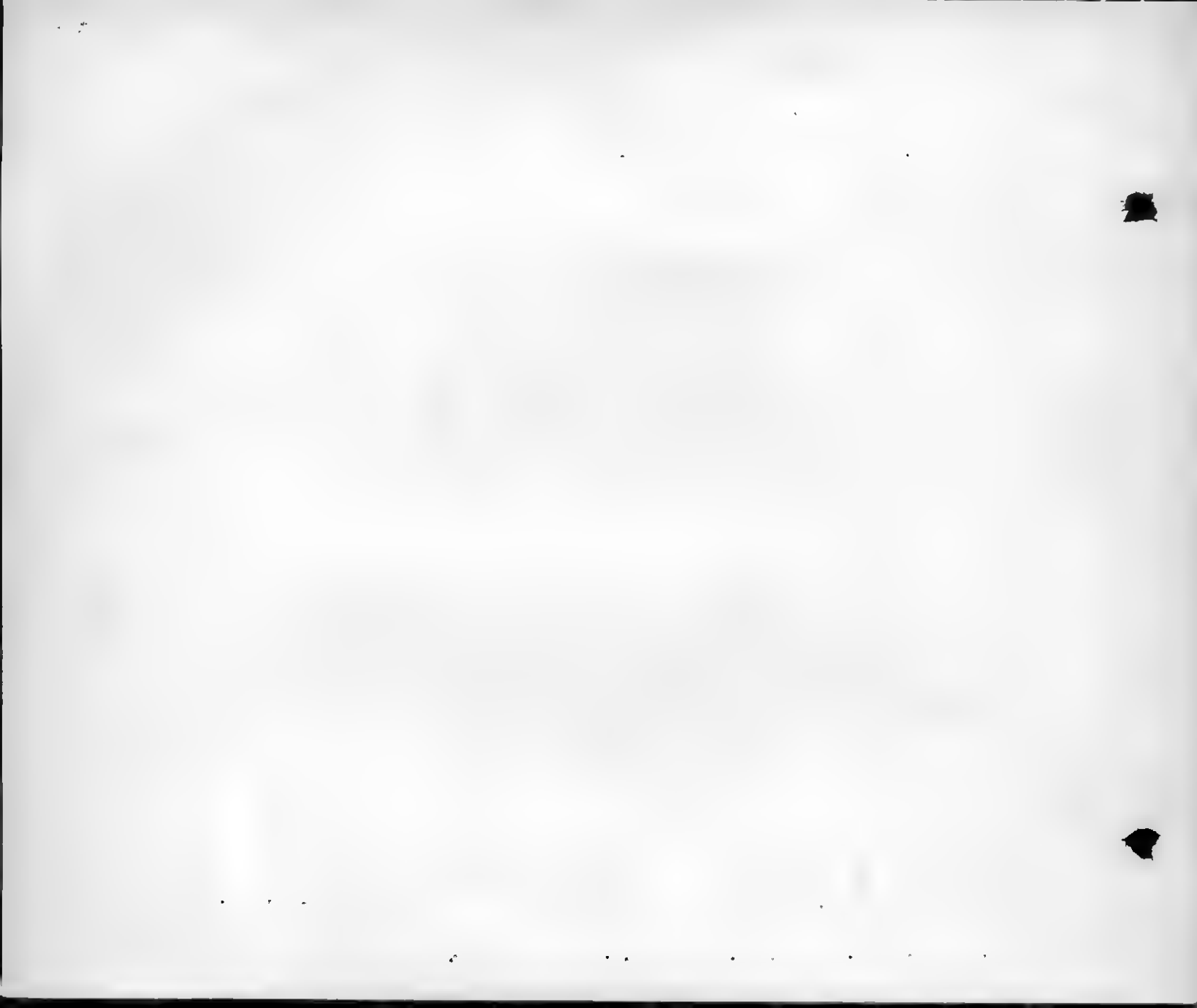
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11153

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE | | c. LENGTH OF STAY IN 1b 8 YEARS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LILLIAS Middle H Last SHAW | | 4. DATE OF DEATH Month OCT Day 26 Year 1960 | |
| 5. SEX FE | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-20-1867 |
| 9. AGE (In years last birthday) 93 yrs | | 10. IF UNDER 1 YEAR: Months 9 Days 6 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY ENGLAND | |
| 11. BIRTHPLACE (State or foreign country) U.S. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME BEN HOLROYD | | 14. MOTHER'S MAIDEN NAME ELIZABETH JACKSON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Frank R. Smith Jr. Address Cockeysville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO CARDIO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC VASCULAR DISEASE DUE TO (c) 8 YEARS | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 10-3, 1952 to 10-26, 1960 , that (I) (we) last saw the deceased alive on 10-26, 1960 , and that death occurred at 8:40 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Walter T. Kees | | 22b. DATE SIGNED 10/26/60 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER T. KEES | | 22d. ADDRESS COCKEYSVILLE, MD. | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL | 23b. DATE THEREOF Oct. 2, 1960 | 23c. NAME OF CEMETERY OR CREMATORY W. L. Smith Cemetery | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. L. Cook, Inc. ADDRESS 1217 St. Paul St. Baltimore, Md. | | 25a. REC'D BY REGISTRAR OCT 27 1960 25b. REGISTRAR'S SIGNATURE Arthur L. Kees | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

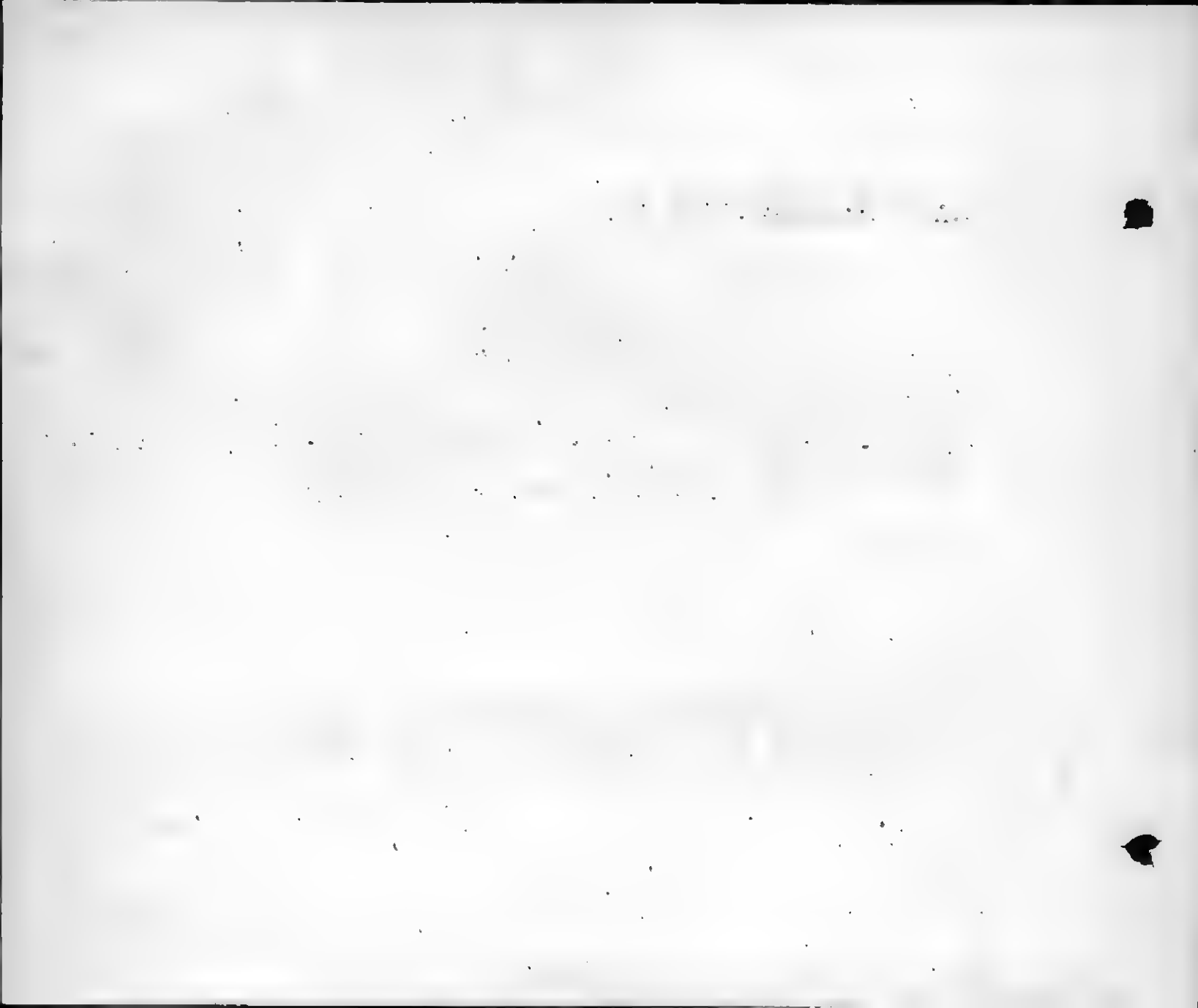
Reg. Dist. No.

11171

11150

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> | |
| c. LENGTH OF STAY IN 1b <u>7 yrs.</u> | | d. STREET ADDRESS <u>2903 Taylor Ave</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2903 Taylor Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Shelley</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 1, 1872</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John Shipley</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna. Bowen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Informant</u> | |
| 17. ADDRESS <u>John Shelley, 2903 Taylor Ave, Balto., Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO <u>Acute myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Bronchopneumonia</u> (b) <u>Acute myocarditis</u> (c) <u>Bronchopneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>12 hours</u> <u>30 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; pernicious anemia</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19 <u>1957</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 22, 1957</u> to <u>Oct 6, 1960</u> that I last saw the deceased alive on <u>Oct 6, 1960</u> , and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H.V. Harbold</u> | | ADDRESS (Street, city or town, state) <u>4706 Harford Road Baltimore, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>H.V. HARBOLD M.D.</u> | | DATE SIGNED <u>Oct 7, 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct 9, 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Freeland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Harstenstein</u> | | ADDRESS <u>New Freedom, Pa.</u> | |
| 24a. REC'D BY REGISTRAR <u>Arthur L. Kline</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | |
| DATE <u>OCT 11 '60</u> | | | |

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 11155 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point Dispensary</u> DOA | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beth. Steel Co. Dispensary</u> | | | | | d. STREET ADDRESS <u>1520 F Street</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>R.</u> Last <u>Sherbert</u> | | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1960</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 4, 1918</u> | | 9. AGE (In years last birthday) <u>42</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>illwright</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Lawrence Sherbert</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Carnand</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-00-5007</u> | | 17. INFORMANT Address <u>Mrs. Ida Sherbert 520 F St. 19, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Fracture</u> <u>902.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell 12 ft. landing on his head</u> | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>10/22 1960</u> Hour <u>2:20</u> a.m. <u>p.m.</u> | | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>factory</u> | | | 20f. (City or town) (County) (State) <u>Sparrows Point Balto. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>William V. Lovitt</u> | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>William V. Lovitt</u> | | | | | DATE <u>10-22-60</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>10-26-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem.</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA 7022 Wise Ave. 22, Md.</u> | | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 26 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u> | | |

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11156

11173

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1807 Ruxton Road | | d. STREET ADDRESS 1807 Ruxton Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Henry Elmer Singewald | | 4. DATE OF DEATH Month Day Year October 28 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 2, 1888 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank and Trust | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Joseph T. Singewald | | 14. MOTHER'S MAIDEN NAME Magdalena Dreyer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Same | |
| 17. INFORMANT Mrs. Charlotte Singewald | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arterio-Sclerosis DUE TO (c) Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 30 min Gradual 1 | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 1936 to Oct 28 1960 , that (I) (we) last saw the deceased alive on Oct 28 1960 and that death occurred at 7 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE W. H. Woody | | 22b. DATE SIGNED Nov 1 1960 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. William H. Woody | | 22d. ADDRESS 1403 Park Ave | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF Nov. 1, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons | | 25a. REC'D BY REGISTRAR NOV 1 '60 | |
| ADDRESS 1900 Eutaw Place Baltol | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kinn | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 111174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 111157 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville P.O. c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore-Harrisburg Expressway | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson d. STREET ADDRESS Hillside Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM FRANKLIN SKIPPER | | | | | 4. DATE OF DEATH October 8, 1960 | | | | | | |
| 5. SEX Male | | | | | 6. COLOR OR RACE White | | | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH Aug. 13, 1901 | | | | | | |
| 9. AGE (In years, last birthday) 59 yrs. | | | | | 10. IF UNDER 1 YEAR: Months 5 Days 12 IF UNDER 24 HRS.: Hours 12 Min. 21 | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardner | | | | | 10b. KIND OF BUSINESS OR INDUSTRY W.L.KONE Co. | | | | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | |
| 13. FATHER'S NAME Stephen Skipper | | | | | 14. MOTHER'S MAIDEN NAME Susan Burnham | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. 218-09-4140 | | | | | | |
| 17. INFORMANT Family Records | | | | | Address | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries with fracture of cervical spine 8121 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Pedestrian struck by auto | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 10/8 1960 Hour a.m. p.m. | | | | | 20d. INJURY OCCURRED: 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Expressway While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | | | | | |
| 20f. (City or town) Cockeysville, Baltimore | | | | | 20g. (County) Md. | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher, M.D. | | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED 10/10/60 | | | | | | |
| Address (Street, city, town, or county) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 22b. DATE THEREOF Oct. 12, 1960 | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Sater's Cemetery | | | | | 22d. LOCATION (City, town, or county) (State) Lutherville, Maryland | | | | | | |
| 23. FUNERAL DIRECTOR John Burns Sone, Towson, Maryland | | | | | 24a. REC'D BY REGISTRAR ACT 13 '60 | | | | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | | | | | | | | | | | |



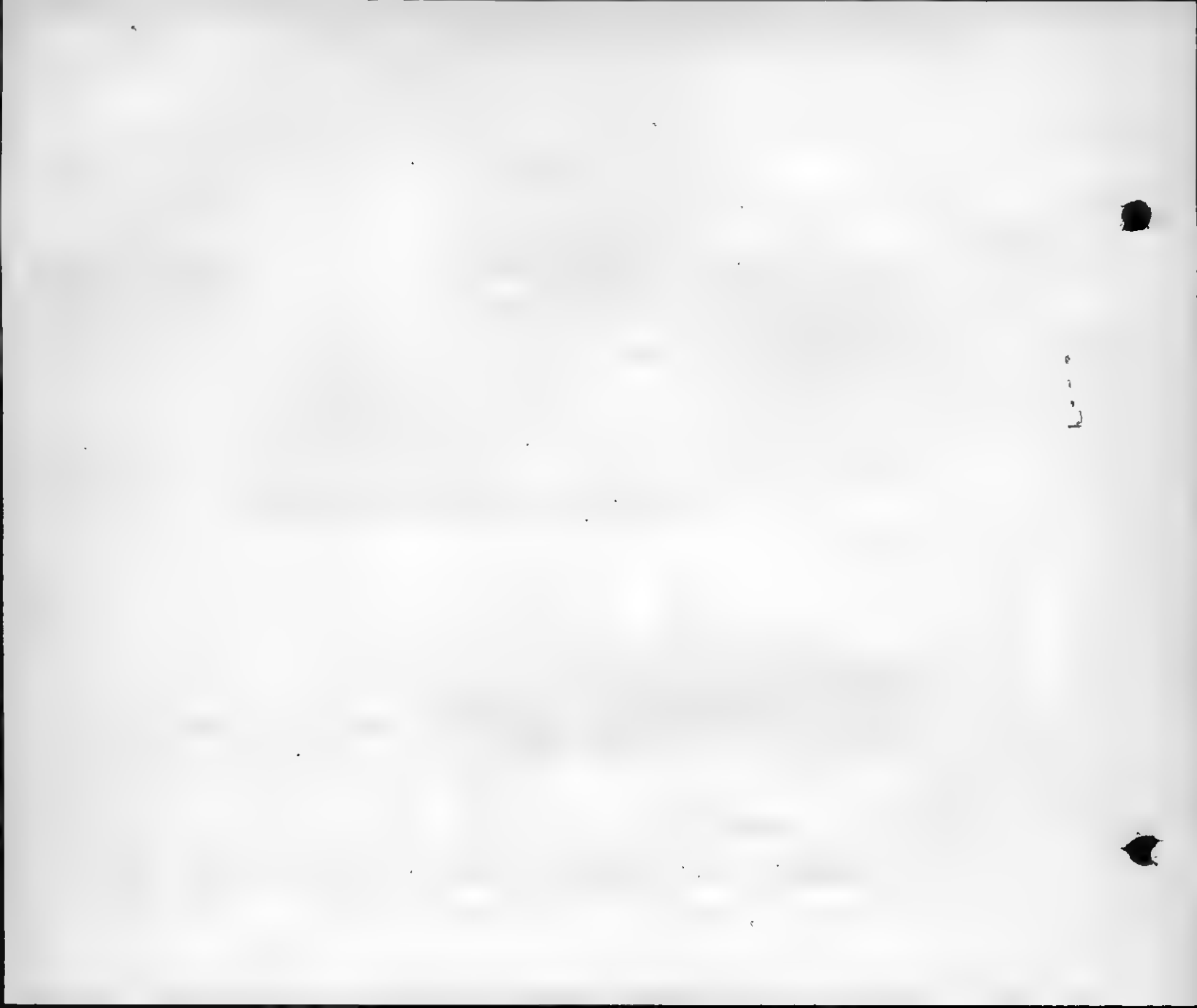
11175

11175 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11158

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 6 Hrs 10 Min | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 1659 N. Milton Ave | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First BERTRAM Middle M Last SMITH | | 4. DATE OF DEATH Month October Day 5 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 14, 1910 |
| 9. AGE (In years lost birthday) 50 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Multilift operator | | 10b. KIND OF BUSINESS OR INDUSTRY Bank | |
| 11. BIRTHPLACE (State or foreign country) Minnesota | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME Joseph Smith | | 14. MOTHER'S MAIDEN NAME Elma Graham | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 475-07-8629 | |
| 17. INFORMANT Clin. Rec., VAH Balto 18, Md Ft Howard Div. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 11:10PM | 20f. (City or town) (County) (State) 5:20AM |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 4, 1960 to October 5, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 5, 1960 , and that death occurred at 5:20A M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Frederick S Donaldson</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S DONALDSON, MD | | 22d. ADDRESS VAH Balto 18, Md Ft Howard Div. | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial | 23b. DATE THEREOF Oct. 10, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Balto | 23d. LOCATION (City town, or county) (State) Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE John C Miller 2431 E Oliver St Balto Md | | 25a. REC'D BY REGISTRAR DATE OCT 7 '60 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kears</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

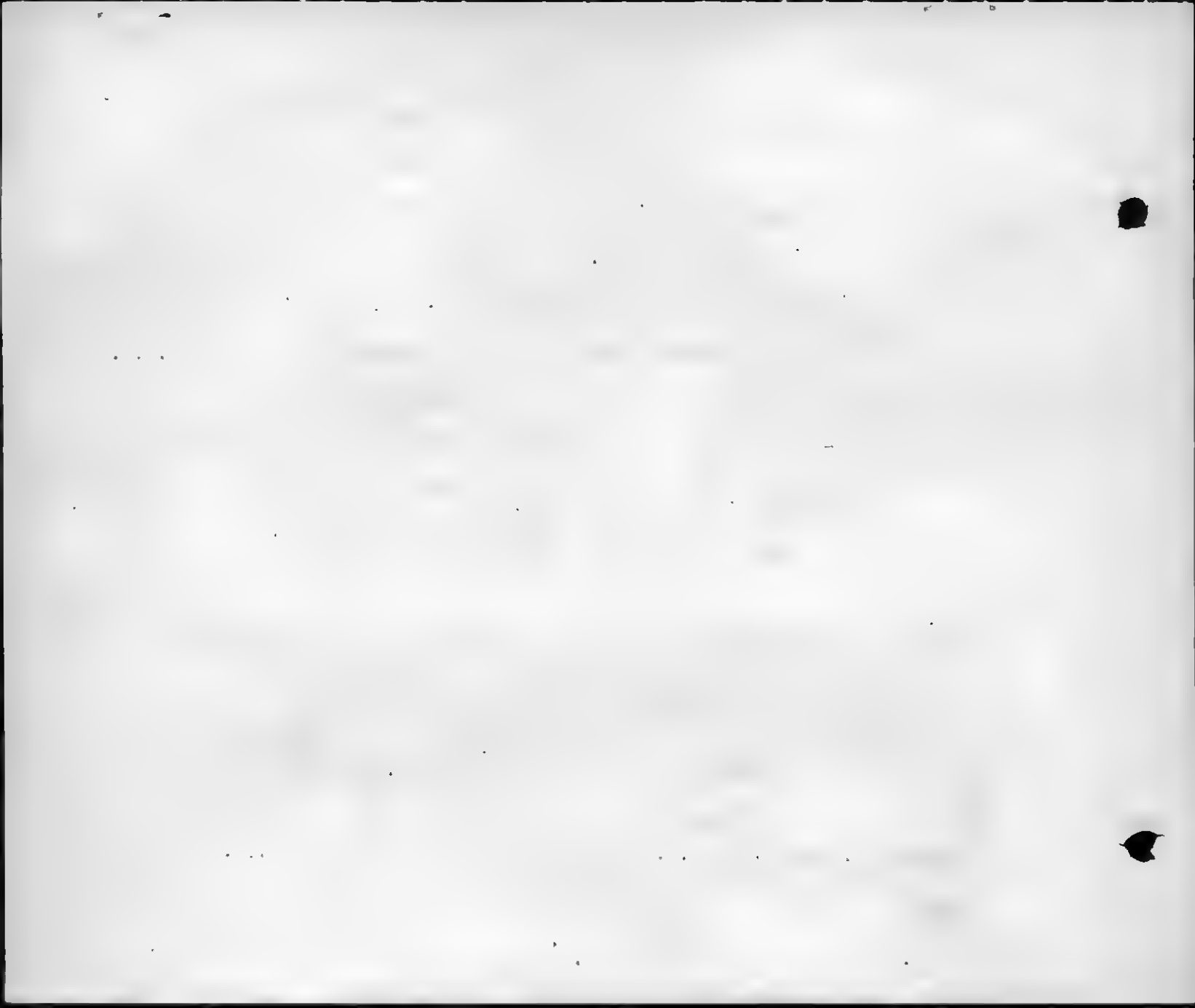


11176

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11159

| | | | | | | | |
|--|------------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | | | c. LENGTH OF STAY IN 1b 162 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. STREET ADDRESS 1301 MADISON AVENUE | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First DANIEL Middle F. Last SMITH | | | | 4. DATE OF DEATH Month OCTOBER Day 18 Year 19 60 | | | |
| 5. SEX MALE | 6. COLOR OR RACE COLORED | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCTOBER 7, 1893 | 9. AGE (In years last birthday) 67 yrs | 10. UNDER 1 YEAR Months Days Hours Min. | 11. UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENER | | | | 10b. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME GEORGE SMITH | | | | 14. MOTHER'S MAIDEN NAME MARY WESLEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW-1 | | | | 16. SOCIAL SECURITY NO 215-32-0927 | | | |
| 17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA AND PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c). Bilateral Hydronephrosis CARCINOMA OF BLADDER, PARTIALLY REMOVED, WITH FISTULA TO THE SKIN ARTERIOSCLEROTIC HEART DISEASE | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3+ DAYS UNKNOWN UNKNOWN UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial Cystectomy - Operation 6/7/60. Excision of Fistula & Closure of Bladder 9/25/60 | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 2, 1960 , to October 18, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 18, 1960 , and that death occurred at PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Frederick S. Donaldson</i> | | | | 22b. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | | 22c. DATE 10/19/60 | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10-24-60 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i> | | | | 25a. REC'D BY REGISTRAR 802 Madison Ave., Baltimore, Md. | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i> | |
| 25c. DATE OCT 21 '60 | | | | | | | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

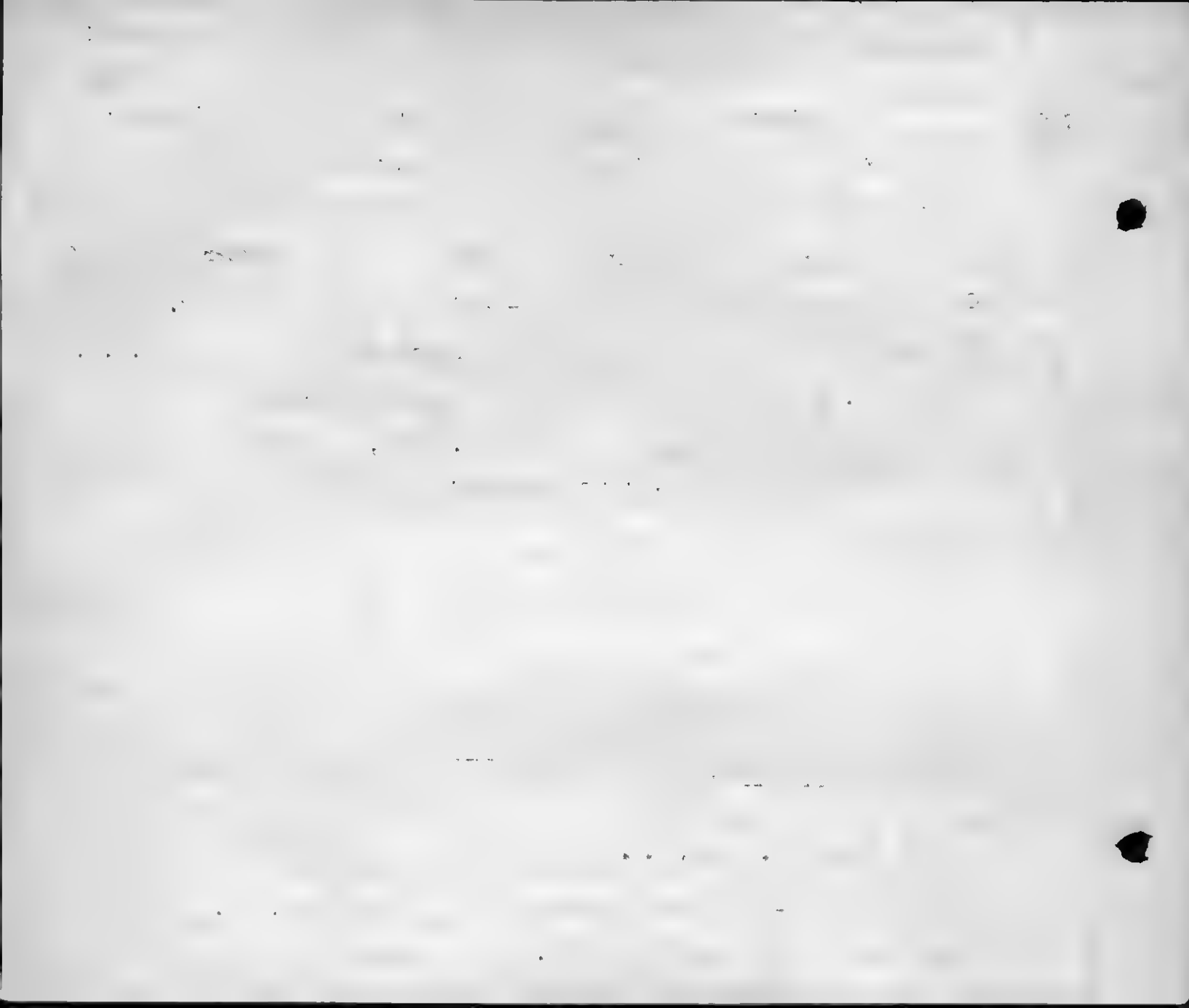
VS. A15ME
5M 7/59

11177
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11160

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Sparks | | c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Sparks | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cedar Grove Road | | d. STREET ADDRESS Cedar Grove Road | |
| 3. NAME OF DECEASED (Type or print) First David Middle Henry Last Snow | | 4. DATE OF DEATH Month October Day 15 Year 1960 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-7-60 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland, Baltimore | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME David H. Snow | | 14. MOTHER'S MAIDEN NAME Bette Flanagan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT David H. Snow, | | Address above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis 525 X Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Petty, M.D. | | DATE SIGNED 10/15/60 | |
| EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-17-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Grove | | 22d. LOCATION (City, town, or country) (State) Parkton, Md. | |
| 23. FUNERAL DIRECTOR Brooks Funeral Service, Towson 4, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 19 '60 | |
| 24b. REGISTRAR'S SIGNATURE Charles S. Petty | | | |

2044141XV5



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2,8,9 Film G273 10-18-60 et

CERTIFICATE OF DEATH

11161
Reg. Dist. No.

11178

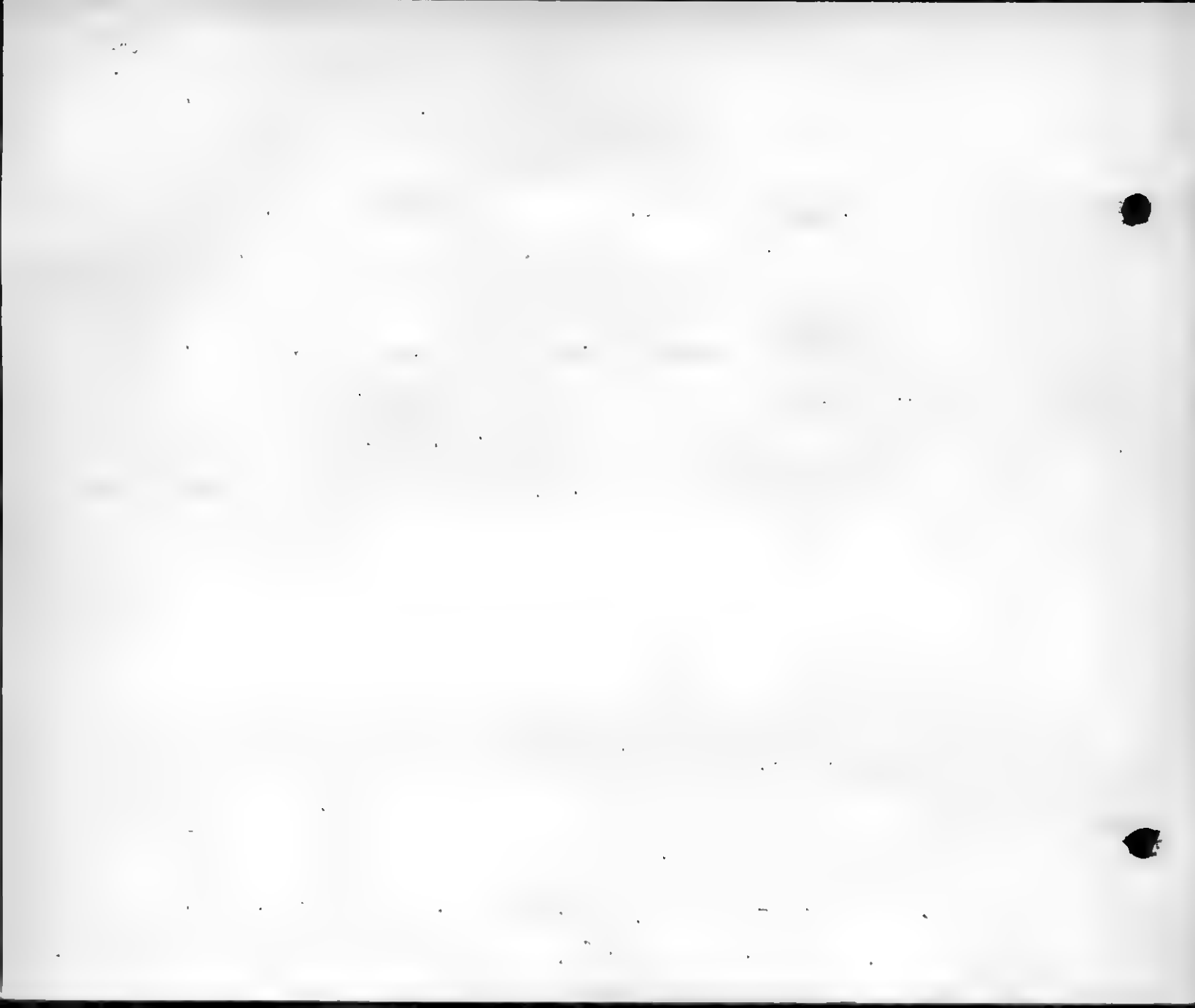
| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>1</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8101 Parkdale Rd.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>Solli</i> Last <i>Solli</i> | | 4. DATE OF DEATH Month <i>10</i> Day <i>10</i> Year <i>1960</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 18, 1915</i> |
| 9. AGE (In years last birthday) <i>45</i> yrs. | | 10. IF UNDER 1 YEAR Months <i>45</i> Days <i>10</i> Hours <i>19</i> Min. <i>60</i> | 11. IF UNDER 24 HRS Months <i>45</i> Days <i>10</i> Hours <i>19</i> Min. <i>60</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Bendix Radio</i> | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Hans Solli</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Kristine Moon</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <i>Sarah M. Solli</i> | | 17. INFORMANT Address <i>same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Malignant Brain Tumor inoperable</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1952</i> DUE TO (c) <i>Sept 59</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Sept 1959</i> to <i>Oct 10, 1960</i> , that I last saw the deceased alive on <i>Sept 30, 1960</i> , and that death occurred at <i>4 A</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Erwin E. Mayer</i> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <i>The Explainer 17 Baltimore 12 2nd</i> | |
| PHYSICIAN'S NAME (Type) <i>ERWIN E. MAYER</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 22b. DATE THEREOF <i>10-13-60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | 24a. REC'D BY REGISTRAR DATE <i>OCT 13 '60</i> | |
| ADDRESS <i>5305 Harford Rd.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i> | |

VS A15 (4)
ISM 9/58

8
1
X
(M)
X

TO HOSPITAL
may be re-
by the hospi-
to FUNERAL
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
by the hospi-
to FUNERAL
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

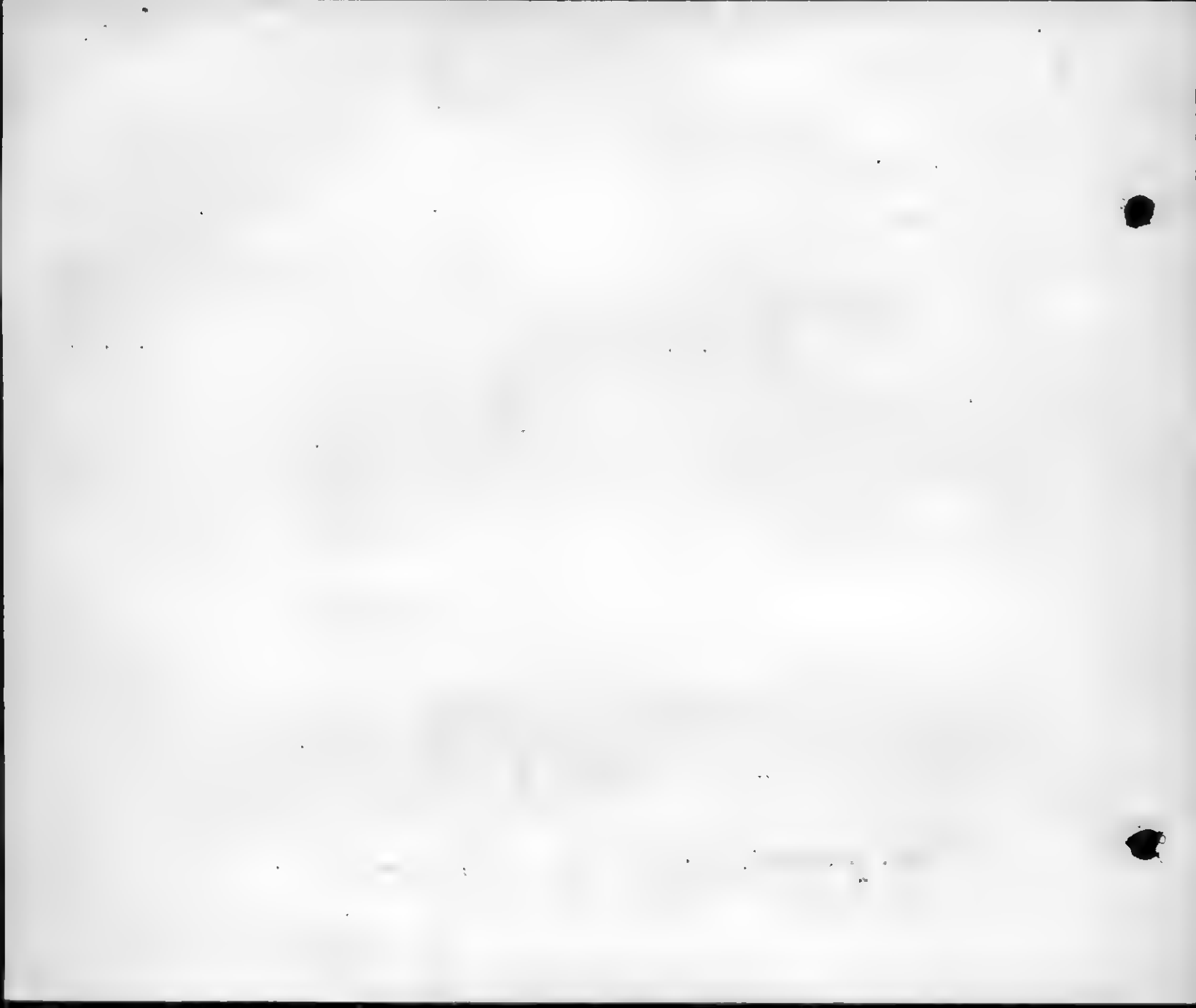
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11179

11162

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | c. LENGTH OF STAY IN 1b 55 Days | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 1030 N. Luzerne Avenue (5) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First JAMES | | Middle R. | | Last SPENCER | | 4. DATE OF DEATH Month October | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 16, 1923 | | 9. AGE (In years last birthday) 37 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. A. Army | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Robert Spencer | | | | 14. MOTHER'S MAIDEN NAME Mildred | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 7/20/42-7/15/60 | | 17. INFORMANT CLINICAL RECORDS VAH, Baltimore 18, Md. FORT HOWARD DIVISION | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 153. CARCINOMA OF COLON WITH WIDESPREAD METASTASES IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Sept. 14, 1960 | | (County) (State) | |
| 21. I certify that 21 (this hospital) attended the deceased from Sept. 14, 1960 to Oct. 26, 1960 , that (he) last saw the deceased alive on Oct. 26, 1960 , and that death occurred at A M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Walter J. Pijanowski | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE 10/26/60 | | | |
| 22c. PHYSICIAN'S ADDRESS WALTER J. PIJANOWSKI, M.D. | | | | 22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/1/60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson | | | | ADDRESS 1000 Beaulieu Ave | | 25a. REC'D BY REGISTRAR OCT 28 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

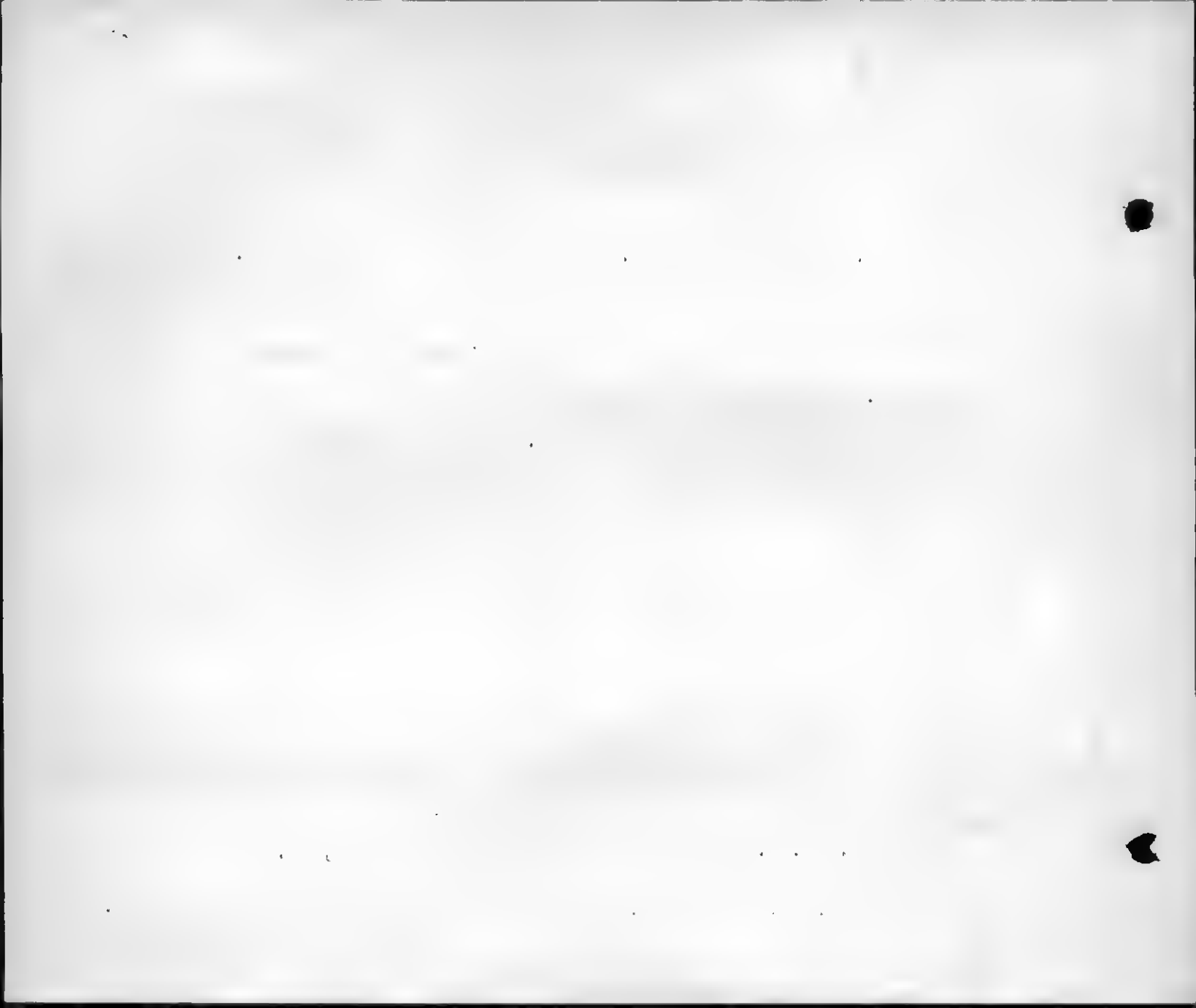
VR A15 (4)
15M 9/59

11180

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11163

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Granite c. LENGTH OF STAY IN 1b 3 1/2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Offutt Road | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite d. STREET ADDRESS Offutt Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mr. George Middle P. Last Stanfield | | 4. DATE OF DEATH Month Oct. Day 28 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 26, 1867 |
| 9. AGE (In years last birthday) 93 yrs | | 10. IF UNDER 1 YEAR Months 93 Days 0 Hours 0 Min 0 | |
| 10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Randallstown, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George W. Stanfield | | 14. MOTHER'S MAIDEN NAME Amelia Beckley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. XXXXXXXXXXXX | |
| 17. INFORMANT Mr. Edward Stanfield | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart-Failure DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH 1 hour | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/11/60 to 10/28/60 , that (I) (we) last saw the deceased alive on 10/28/60 , and that death occurred on 10/28/60 from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. Wm. E. Martin | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Wm. E. Martin | | 22d. ADDRESS Randallstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 31, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Paran | | 23d. LOCATION (City, town, or county) (State) Harrionsville, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers | | 25a. REC'D BY REGISTRAR NOV 4 '60 | |
| ADDRESS 8728 Liberty Road Randallstown, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraw | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111181

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11164

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 16 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 10-1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (22) 53 d. STREET ADDRESS 113 Balnew Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JAMES J. STAPLES | | | | 4. DATE OF DEATH Month Day Year October 27 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 20, 1907 | |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS. Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Company | | 11. BIRTHPLACE (State or foreign country) Keysville, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Dock Staples | | | | 14. MOTHER'S MAIDEN NAME Mary Stokes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO 083-10-3827 | | 17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE BRONCHOGENIC CARCINOMA WITH METASTASIS TO THE BRAIN 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11 of Oct. 1960 to 27 of Oct. 1960 , that (I) (we) last saw the deceased alive on October 27 1960 , and that death occurred at 12:20 A. M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Frederick S. Donaldson | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE 10/27/60 | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | | | 22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV. | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-31-60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Charles R. Law Mortuary | | | | ADDRESS 802 Madison Ave., Baltimore 1, Md. | | 25a. REC'D BY REGISTRAR Oct 31 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles R. Law | | | |

M

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RP



1
FOR STATE HEALTH DEPT. (M)
572
1
2
2
12

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any body is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before adm ssion) | | 3. NAME OF DECEASED | | 4. DATE OF DEATH | | 5. SEX | | 6. COLOR OR RACE | |
| a. COUNTY | | b. COUNTY | | First Middle Last | | Month Day Year | | Male Female | | White Black | |
| Baltimore | | Maryland | | Howard William Stromberg | | Oct. 6 1960 | | | | | |
| b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| Owings Mills | | Baltimore City | | 28 yrs. | | 7-28-18 | | 42 yrs | | none | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | d. STREET ADDRESS | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Rosewood State Training School | | 1100 Cooks Lane | | Baltimore, Md. | | U.S.A. | | Edward D. Stromberg | | Mary E. Tucker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | INTERVAL BETWEEN ONSET AND DEATH | |
| no | | none | | Rosewood St. Tr. School | | Owings Mills, Md. | | 18a. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Food est. 1 hr. | | 18b. Atelectesis due to Fecal Impaction est. 6 hrs. | |
| 18c. Pneumonitis est. 1 hr. | | 18d. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anoxia | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none, 9 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) none | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| Burial | | Oct-8-1960 | | New-Cathedral Bn. Balto. Md. | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | | 22e. CHIEF MEDICAL EXAMINER | |
| 23. FUNERAL DIRECTOR | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | 22f. ASSISTANT MEDICAL EXAMINER | | 22g. DEPUTY MEDICAL EXAMINER | |
| S. Turner | | 3512 Fred. Ave. | | OCT 13 '60 | | G. L. K. K. | | D. D. Caples, M. D. | | DATE SIGNED 10-7-60 | |



CERTIFICATE OF DEATH

Reg. Dist. No. 11166

11183

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE AS b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 31 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TODD AVE | | e. STREET ADDRESS #1 | |
| 3. NAME OF DECEASED (Type or print) DAISY First B. SURRETT Middle SURRETT Last | | 4. DATE OF DEATH Oct Month 6 Day 1960 Year | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAR 21 1891 |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Richard Johnson | | 14. MOTHER'S MAIDEN NAME Ella Bendall | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT Wm. Surratt Address as in #1 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular disease 15 yrs DUE TO (c) Cerebral Hemorrhage hemiplegia 11 yrs | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1945 , 19____, to Oct 6 , 1960, that I last saw the deceased alive on Sept 30 , 19 60 , and that death occurred at _____ M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Louis N. Tolin | | ADDRESS (Street, city or town, state) 6908 N. POINT RD. DATE SIGNED 10/6/60 | |
| PHYSICIAN'S NAME (Type) LOUIS N. TOLIN | | BALTIMORE-19-MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF Oct. 10, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. | 22d. LOCATION (City, town, or county) (State) Washington Hvd. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA ADDRESS 7922 Wise Ave. 22, Md. | | 24a. REC'D BY REGISTRAR OCT 11 '60 24b. REGISTRAR'S SIGNATURE Carles S. F... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

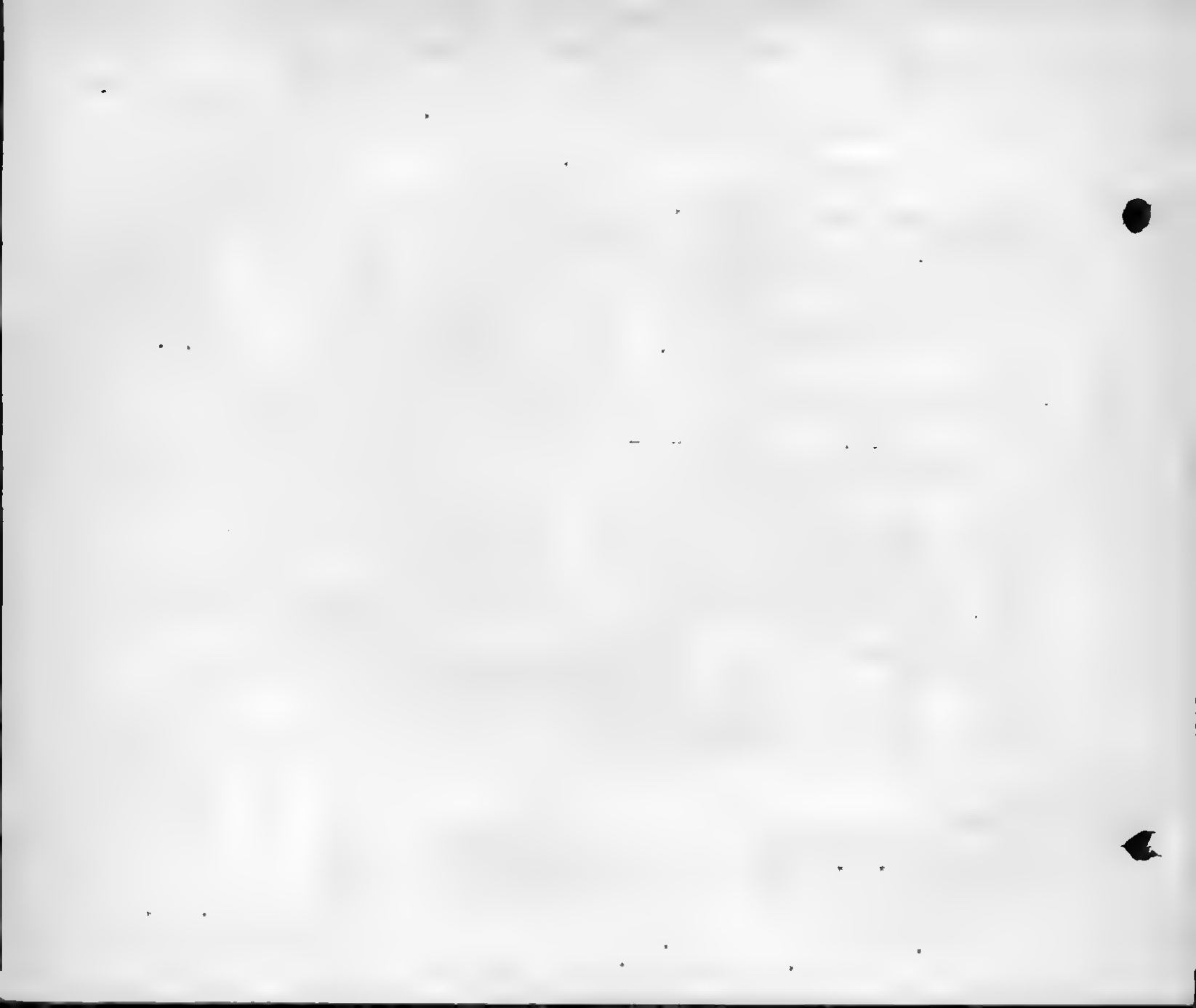
Reg. Dist. No.

11184

11167

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore | | c. LENGTH OF STAY IN 1b 30 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4206 Old North Point Rd. | | d. STREET ADDRESS 4206 Old North Point | |
| 3. NAME OF DECEASED (Type or print) JOHN F. TELLANOWSKI (TALIANOKY) | | 4. DATE OF DEATH 10 Month 24 Day 19 Year 60 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/26/1901 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deisel operator | 11. BIRTHPLACE (State or foreign country) Poland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Joseph Telmanowski | |
| 14. MOTHER'S MAIDEN NAME Catherine Lysakowski | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes J.W.I. | |
| 16. SOCIAL SECURITY NO 213-09-3733 | | 17. INFORMANT Helen Telmanowski Address 4206 Old North Point | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior-Septal-Cardiac-Infarction DUE TO DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. Davis | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. Davis | | DATE SIGNED 10/25/60 | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/29/60 | 22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John W. Weber & Sons Inc. ADDRESS 401 S. Chester St. | | 24a. REC'D BY REGISTRAR OCT 27 '60 | 24b. REGISTRAR'S SIGNATURE William S. Hines |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 7/59

MEDICAL CERTIFICATION

| <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>11044</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>11168</div> <div>1</div> </div> </div> | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown, Md. c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1 Cherry Hill Road | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md. d. STREET ADDRESS 330 Tollgate Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) GILBERT S. THOMPSON | | | | 4. DATE OF DEATH Oct. 10 19 60 | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 18, 1890 | | 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener | | | | 10b. KIND OF BUSINESS OR INDUSTRY Gardening | | 11. BIRTHPLACE (State or foreign country) Carroll Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Edward Thompson | | | | 14. MOTHER'S MAIDEN NAME Carrie Collins | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Viola E. Thompson 330 Tollgate Road, Owings Mills, Md. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 20. 1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. none p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) none | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 10-11-60 | | | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Balto. Co., Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 10-13-60 | | 22c. NAME OF CEMETERY OR CREMATORY Family lot | | 22d. LOCATION (City, town, or country) Johnsville, Md. | | | |
| 23. FUNERAL DIRECTOR Holland Funeral Home, 1631 Druid Hill Ave., Baltimore, Md. | | | | | | 24a. REC'D BY REGISTRAR DATE OCT 14 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |



11185

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11169
Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 13yr8mth27dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V31.4 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 1608 Carswell Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle C. Last Thrasher | | | | 4. DATE OF DEATH Month October Day 2 Year 19 60 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 13, 1904 | | 9. AGE (In years last birthday) 56 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | 10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. | | 11. BIRTHPLACE (State or foreign country) Philadelphia Pa. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William Clifton Thrasher | | | | 14. MOTHER'S MAIDEN NAME Eleanor Simmons P. Simmons | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknowns) no | | 16. SOCIAL SECURITY NO. 705-03-4831 | | 17. INFORMANT Records, SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia <i>Pending</i> 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis Acute DUE TO (c) Fracture hip left | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks 26 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) At University Hospital (brain softening), Chronic Schiz. (Smith Peterson nailing with McGlaughlin attachment performed 8-18-60) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) At 4:30 a.m. on 8-6-60 pt. fell from bed, sustaining intertrochanteric frac. left femur. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 4:30 a.m. 8-6 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | | 20f. (City or town) (County) (State) Catonsville 28, Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>William E. McGrath</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | |
| EXAMINER'S NAME (Type) William E. McGrath, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 10-3-60 | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 10-5-60 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd. | | | | 24a. REC'D BY REGISTRAR DATE OCT 7 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 E. 100 var. ST

100 30

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATE

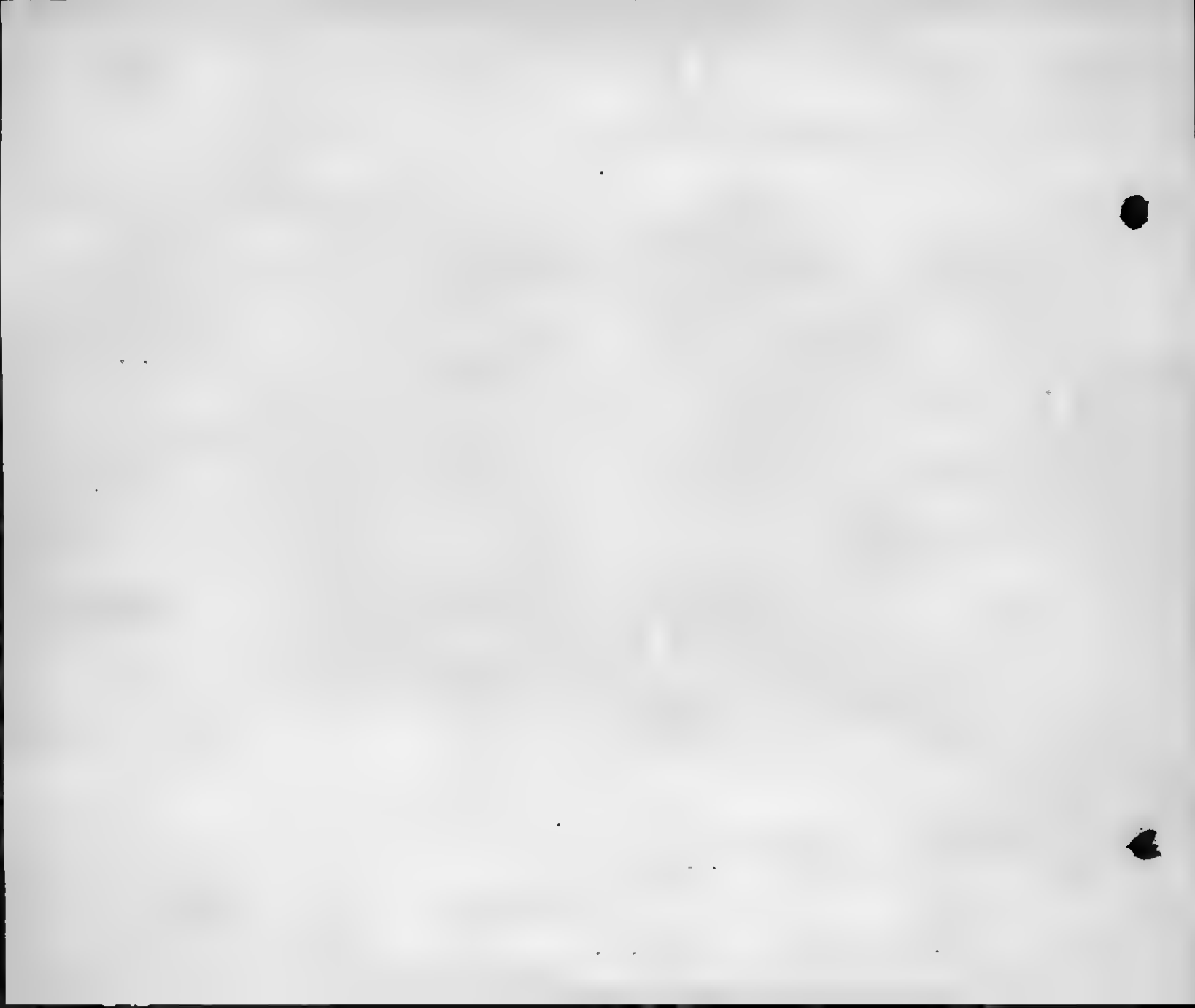
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11170

| | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | c. LENGTH OF STAY IN 1b 16 yrs. | | 2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland | | b. COUNTY City | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk, | | d. STREET ADDRESS 2934 Yorkway | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School | | 3. NAME OF DECEASED (Type or print) ALBERT | | 4. DATE OF DEATH 10 24 19 60 | | 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/19/35 | | 9. AGE (In years last birthday) 25 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Albert Clellon Thurmond | | 14. MOTHER'S MAIDEN NAME Mildred Pearl Faught | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no | | 16. SOCIAL SECURITY NO | | | |
| 17. INFORMANT Rosewood State Training School Records | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia, acute 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Chronic brain damage | | INTERVAL BETWEEN ONSET AND DEATH 15 days | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Cirrhosis of liver | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. no | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | 20c. TIME OF INJURY Month, Day, Year none 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) none | | (County) none | | (State) none | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| ACTUAL SIGNATURE D.D. Caples | | EXAMINER'S NAME (Type) D. D. Caples, M.D. | | M.D. | | DATE SIGNED 10-25-60 | | 22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct 31, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Horse Cave City Cemetery | | 22d. LOCATION (City, town, or country) Horse Cave, Kentucky | | | |
| 23. FUNERAL DIRECTOR J.F.Eline & Sons, Reisterstown, Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE NOV 1 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kinn | | | | | | | | | | | |



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11187

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

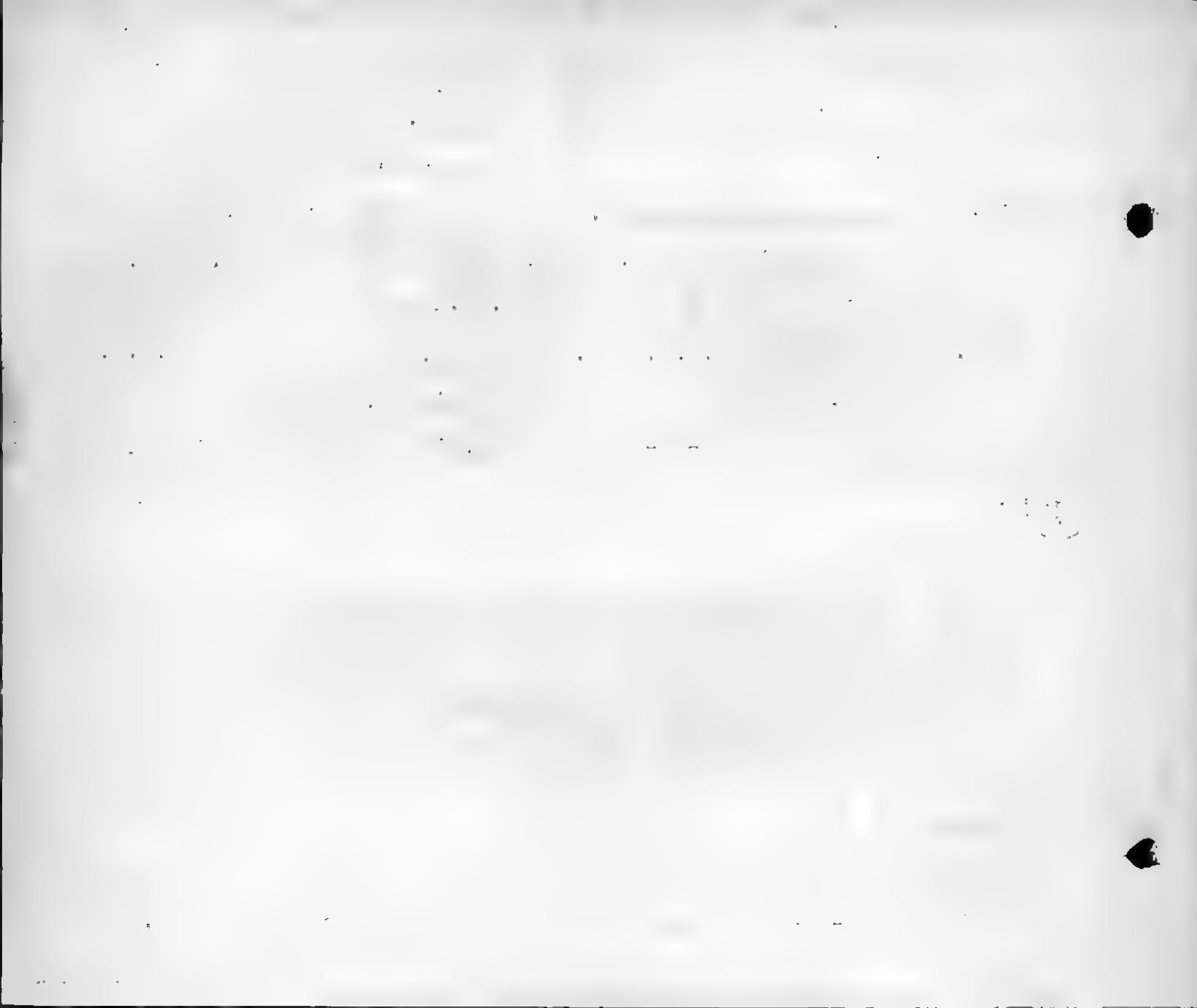
CERTIFICATE OF DEATH

11171
Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor for Aged & Conv. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3 NAME OF DECEASED (Type or print) First William Middle T. Last Tinsley | | 4. DATE OF DEATH Month Oct. Day 11 , Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 20, 1885 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY U.S.F. & G. | 9. AGE (In years last birthday) yrs. 75 |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles L. Tinsley | | 14. MOTHER'S MAIDEN NAME Caroline W. Washum | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO 215-07-8240 | |
| 17. INFORMANT Barto G. Tinsley | | Address 3424 Mayfair Rd. (7) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized arteriosclerosis DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH Days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1958 to Oct 11, 1960 , that I last saw the deceased alive on Oct 9, 1960 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Nelson McKay | | ADDRESS (Street, city or town, state) DATE SIGNED 6014 EDMONDSON AVE Balto Md 10/11/60 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10-15-1690 | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park | 22d. LOCATION (City, town, or county) (State) Woodlawn Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong | | ADDRESS 3107 W. North Ave | 24a. REC'D BY REGISTRAR OCT 17 '60 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)
15M 9/59

111188

11172

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 7 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (6) d. STREET ADDRESS 8900 Lenning Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last TOBOLL, JR. | | 4. DATE OF DEATH Month October Day 21 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 15, 1919 |
| 9. AGE (In years lost birthday) 41 yrs | | 10. IF UNDER 1 YEAR Months 41 Days 19 Hours 60 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Raspeburg, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Charles W. Toboll, Sr. | | 14. MOTHER'S MAIDEN NAME Bertha Iutz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Clinical Records VAH, Baltimore 18, Md. FORT HOWARD DIVISION | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC ALCOHOLISM DUE TO (c) BRONCHOPNEUMONIA | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS MANY YEARS 9 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from October 11, 1960 to October 21, 1960 , that (I) (we) last saw the deceased alive on October 21, 1960 , and that death occurred at 3:10 P. M. from the causes and on the date stated above | | | |
| 22a. SIGNATURE Charles E. Rowan M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN | | 22b. DATE SIGNED 10-22-60 22d. ADDRESS M.D. VAH Balto 18 Md - Ft Howard Div | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-25-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Church Cem. | | 23d. LOCATION (City, town, or county) (State) Balto. Maryland. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Funeral Home Address 6009 Harford Road Baltimore 14 Md | | 25a. REC'D BY REGISTRAR DATE OCT 26 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11189

11173

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 12 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) S.A. ^{First} WALTER ^{Middle} FRANK ^{Last} UNVERZAGT UNVERZAGT | | | | 4. DATE OF DEATH Month October Day 5 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH November 19, 1892 | |
| 9. AGE (In years lost birthday) 67 yrs | | F UNDER 1 YEAR Months 6 Days 4 Hours 15 Min. | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | |
| 13. FATHER'S NAME Augustus Unverzagt | | | | 14. MOTHER'S MAIDEN NAME Ida Cullerson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | | | 16. SOCIAL SECURITY NO. 219-07-3121 | | 17. INFORMANT Clinical Records, VAH Balto 18, Md., Ft Howard Div. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420. PULMONARY EDEMA DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. CORONARY INSUFFICIENCY (b) DUE TO (c) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 1 Day UNKNOWN UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/23 to 10/5 , that (we) lost saw the deceased alive on 10/5/60 , and that death occurred at 11:15 A.M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>Frederick S. Donaldson</i> | | | | 22b. DATE 10/5/60 | | 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d. ADDRESS VAH Balto 18 Md Ft Howard Div. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-7-60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight, Inc</i> | | | | 25a. REC'D BY REGISTRAR OCT 7 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Charles S. Kneass</i> | |
| 25c. ADDRESS Wm Cook-Blight Inc 6009 Harford Rd Balto 14, Md | | | | | | | |



may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11190

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11174

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 32yr 10mth | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Frank Middle Nicholas Last Vereker | | | | 4. DATE OF DEATH Month October Day 31 Year 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 22 1899 | | 9. AGE (in years last birthday) 61 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | | 10b. KIND OF BUSINESS OR INDUSTRY farming | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James J. Vereker | | | | 14. MOTHER'S MAIDEN NAME Alice Kelly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis DUE TO (c) Arteriosclerotic cardiovascular disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1 to Oct. 31 , 19 60 , that (I) (we) last saw the deceased alive on Oct. 31 , 19 60 , and that death occurred at 7:30 P. M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Stella Wachslar, M. D. | | | | 22b. DATE SIGNED 11-1-60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial 2/20/61 | | 23b. DATE THEREOF 2/20/61 | | 23c. NAME OF CEMETERY OR CREMATORY St Johns | | 23d. LOCATION (City, town, or county) (State) Long Green - Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Stewart Morris - Balt. Md | | | | 25a. REC'D BY REGISTRAR DATE NOV 3 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur E. Kenna | |



CERTIFICATE OF DEATH

11175

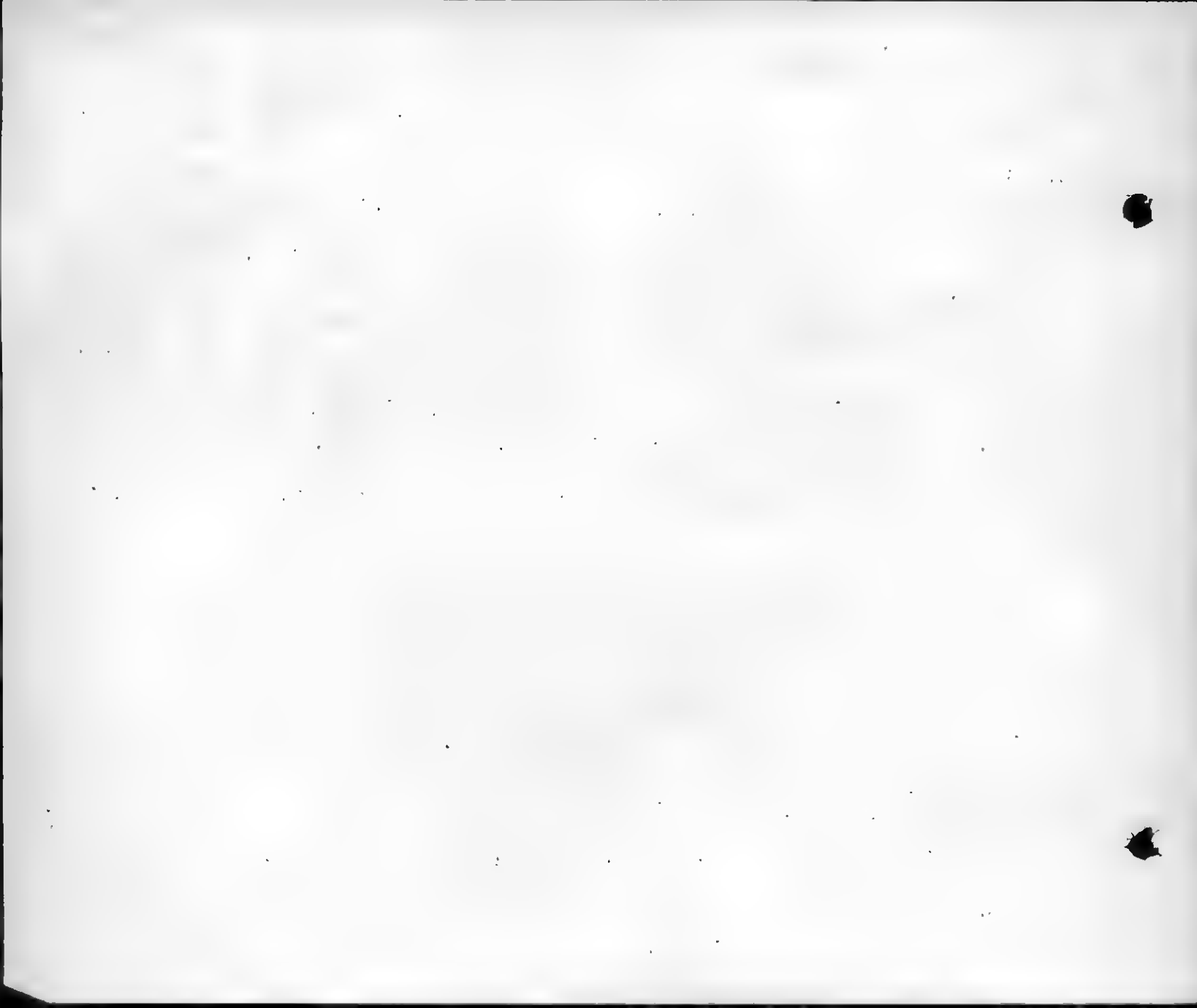
Reg. Dist. No.

11191

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKDALE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3526 MILFORD MILL ROAD | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKDALE d. STREET ADDRESS 3526 MILFORD MILL ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM KARL VOLLAND | | 4. DATE OF DEATH Month Day Year OCT. 4, 1960 19 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 24, 1883 |
| 9. AGE (In years last birthday) 77 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER RETIRED | 11. BIRTHPLACE (State or foreign country) FULLERTON, CANADA |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIAM VOLLAND | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO. 212 09 5275 | | 17. INFORMANT MRS. ELIZABETH K. VOLLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Art. Sclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 29th , 19 50 , to Oct-4th , 19 60 , that I last saw the deceased alive on Sept 30th , 19 60 , and that death occurred at 8:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1331 Reisterstown Rd DATE SIGNED 10/5/60 ACTUAL SIGNATURE James A. Miller M.D. PHYSICIAN'S NAME (Type) James A. Miller M.D. Pikesville - Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 10/7/60 | 22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY | 22d. LOCATION (City, town, or county) (State) WOODLAWN MARYLAND |
| 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. ADDRESS BALTIMORE MARYLAND | | 24a. REC'D BY REGISTRAR OCT 7 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11176

Reg. Dist. No.

11192

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rosedale</i> | | c. LENGTH OF STAY IN 1b <i>1</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7906 Oakdale Rd</i> | | e. STREET ADDRESS <i>7906 Oakdale Rd</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>George G Walter</i> | | 4. DATE OF DEATH Month Day Year <i>Oct 20 1960</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Apr 5 1900</i> |
| 9. AGE (In years last birthday) <i>60</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance Electrician</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Balto Md</i> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Louis S. Walter</i> | | 14. MOTHER'S MAIDEN NAME <i>Mollie M Allen</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <i>216-01-2403</i> | |
| 17. INFORMANT <i>George A Walter</i> | | Address <i>7906 Oakdale Ave</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> DUE TO <i>arterio-sclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>5-yr.</i> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>11/5 1959</i> to <i>10/20 1960</i> , that I last saw the deceased alive on <i>10/19/60</i> , and that death occurred at <i>2 A</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Gordon Grau</i> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <i>1960/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Gordon Grau, M.D. 8523 Loch Raven Blvd, Balto. 4 Maryland</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <i>10/24/60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Louisa Park</i> | 22d. LOCATION (City, town, or county) (State) <i>Balto Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Hunt</i> ADDRESS <i>305 Hartford Rd</i> | | 24a. REC'D BY REGISTRAR DATE <i>OCT 21 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

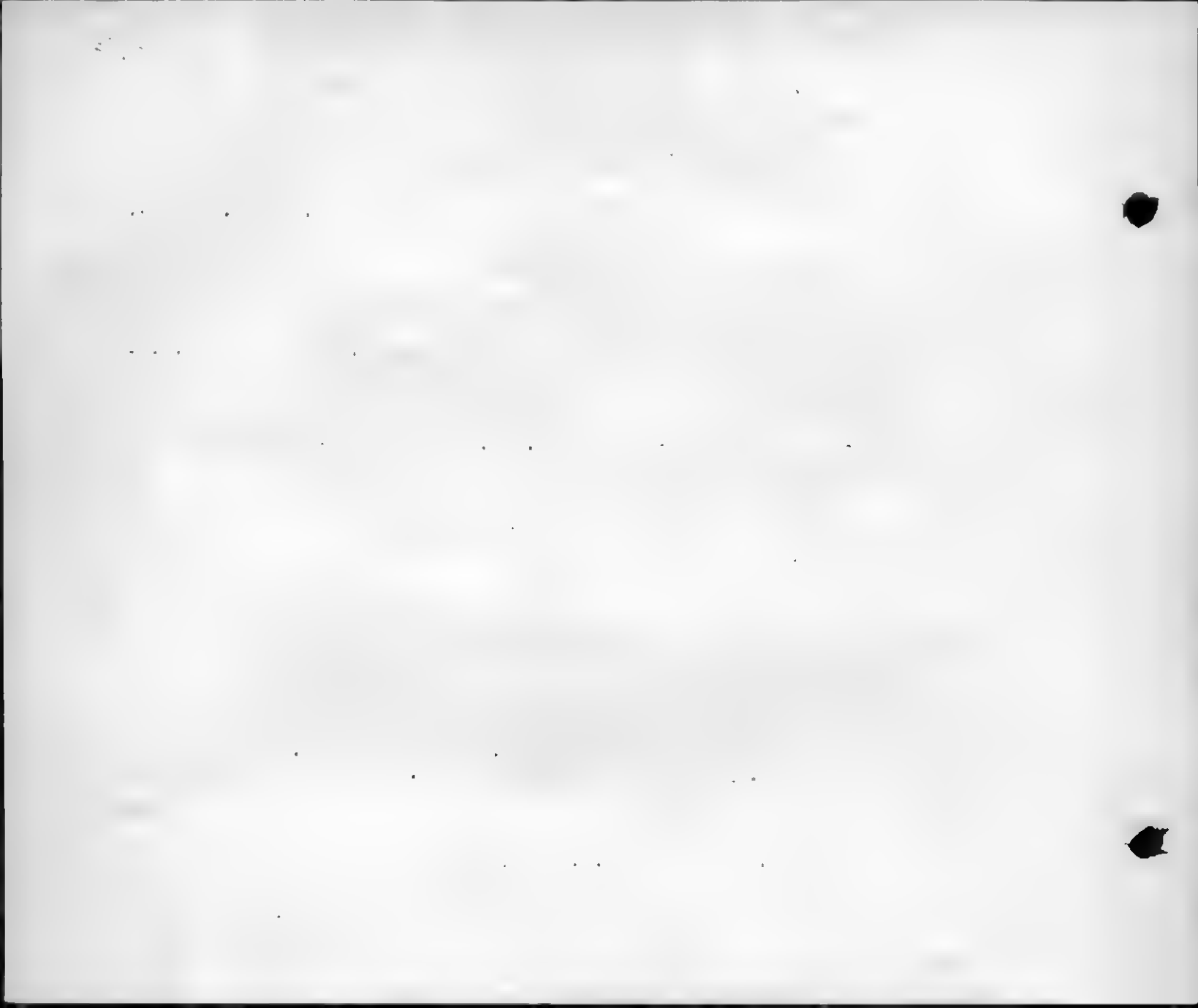
VP A's (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Maryland</u> | | | | c. LENGTH OF STAY IN 1b <u>17 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUST M WALTHER</u> | | | | 4. DATE OF DEATH Month Day Year <u>October 31 1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 6, 1892</u> | |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Joseph A. Walther</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Rauck</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-1</u> | | 16. SOCIAL SECURITY NO. <u>218-12-8345</u> | | 17. INFORMANT <u>Clin. Rec. VAH Balto Md - Fort Howard Division</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>MILD CARDIAC SCARRING</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>Unknown</u> <u>Unknown</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mural Thrombosis, Old; Splenic Infarction, Recent</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 14 8:45</u> to <u>Oct. 31 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 31 1960</u> , and that death occurred at <u>A. M.</u> from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <u>Frederick S. Donaldson, M.D.</u> | | | | 22b. ADDRESS <u>VAH, Fort Howard, Maryland</u> | | 22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/3/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>LEONARD J. RUCK</u> | | | | 25a. REC'D BY REGISTRAR <u>NOV 4 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u> | |



11193

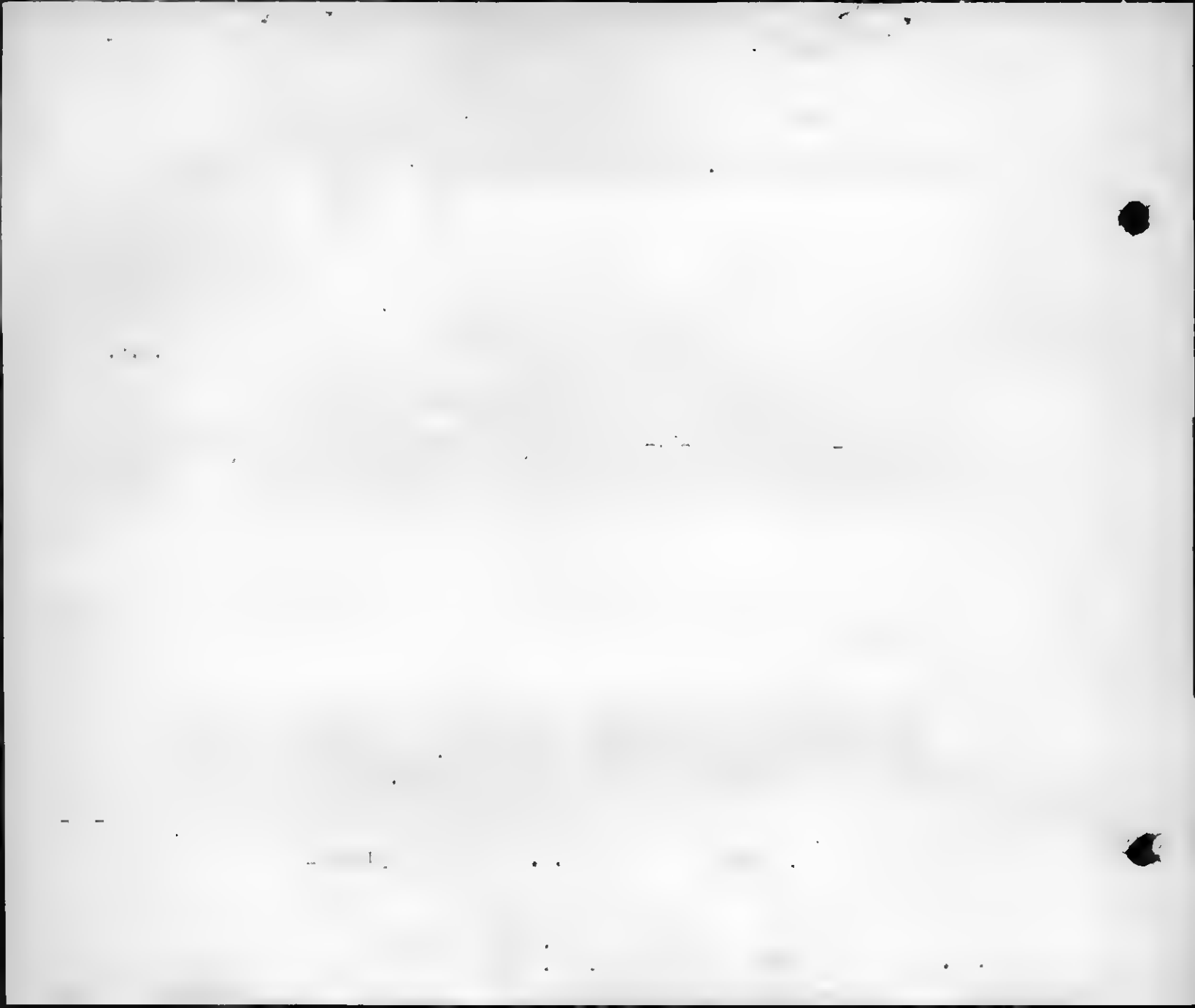
11177



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

| <div style="display: flex; justify-content: space-between;"> <div> <div>11194</div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> </div> <div>11178</div> </div> | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD VETERANS HOSP. | | | c. LENGTH OF STAY IN 1b 15 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 29 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | d. STREET ADDRESS 314 WESTOWNE ROAD | | | | |
| 3. NAME OF DECEASED (Type or print) First EDWARD Middle John Last WARD | | | | | 4. DATE OF DEATH Month OCTOBER Day 21 Year 1960 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 14 1892 | | 9. AGE (In years lost birthday) 68 yrs. IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR | | | 10b. KIND OF BUSINESS OR INDUSTRY SHEET METAL | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM F WARD | | | | | 14. MOTHER'S MAIDEN NAME EMMA ALBERT | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | | 16. SOCIAL SECURITY NO. 213-34-1576 | | 17. INFORMANT Address CLIN REC VAH BALTO MD FT HOWARD DIVISION | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MALIGNANT MELANOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMIPARESIS | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 6, 1960 to October 21, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 21 1960 , and that death occurred at 6:15 p.m. from the causes and on the date stated above | | | | | | | | | |
| 22a. SIGNATURE  | | | | | 22b. DATE SIGNED 10-21-60 | | | | |
| 22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN | | | | | 22d. ADDRESS M.D. VAH BALTO 18 MD - FT HOWARD DIVISION | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF 10/25/60 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY | | 23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS Inc | | | | | 25a. REC'D BY REGISTRAR DATE OCT 24 '60 | | 25b. REGISTRAR'S SIGNATURE  | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

111195

THE STATE OF MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

111179

| | | | |
|---|----------------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Wilson, Maryland | | c. LENGTH OF STAY IN 1b 12 days | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Mt. Wilson State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle T Last WARD | | 4. DATE OF DEATH Month Oct Day 19 Year 1960 | |
| 5. SEX M | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 6/4/07 |
| 9. AGE (In years last birthday) 53 yrs | | 10. IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN WARD, Sr. | | 14. MOTHER'S MAIDEN NAME Emma Selby | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Mt. Wilson State Hospital records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-7-1960 to 10-19-1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-19-1960 , and that death occurred 12:45 PM at the causes and on the date stated above. | | | |
| 22a. SIGNATURE Wm. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent | | 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Oct. 23, 1960 | | 23b. DATE THEREOF Oct. 23, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Stockton Cemetery | | 23d. LOCATION (City, town, or county) (State) Stockton Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE NORMAN DENNIS | | 24. ADDRESS Snowhill, Md. | |
| 25a. REC'D BY REGISTRAR OCT 24 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. P... .. | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11196

CERTIFICATE OF DEATH

11180

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i> | c. LENGTH OF STAY IN 1b <i>124 years</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paper Mill Road</i> | | d. STREET ADDRESS <i>Paper Mill Road</i> | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Clarence Edward Waters</i> | | 4. DATE OF DEATH Month Day Year <i>October 31 1960</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9 April 1902</i> |
| 9. AGE (In years last birthday) <i>58</i> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handscaper</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Sweet Air Balto Co. Md</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>USA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Lawrence Waters</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Ayers</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-28-848</i> | |
| 17. INFORMANT <i>Wife - Same address</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of lower bowel</i> <i>153.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>1950</i> to <i>October 1960</i> , that I last saw the deceased alive on <i>29 Oct 1960</i> , and that death occurred at <i>2 NOON</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D. | | ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i> | |
| DATE SIGNED <i>31 Oct 1960</i> | | | |
| PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | 22b. DATE THEREOF <i>11/3/60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>MT. Zion</i> | 22d. LOCATION (City, town, or county) (State) <i>Long Green, Balto Co. Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Blatnick</i> | | ADDRESS <i>1761 Mt. Cold St. Balto Md.</i> | 24a. REC'D BY REGISTRAR <i>DATE NOV 3 '60</i> |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kne A</i> | |

TO HOSPITAL: 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

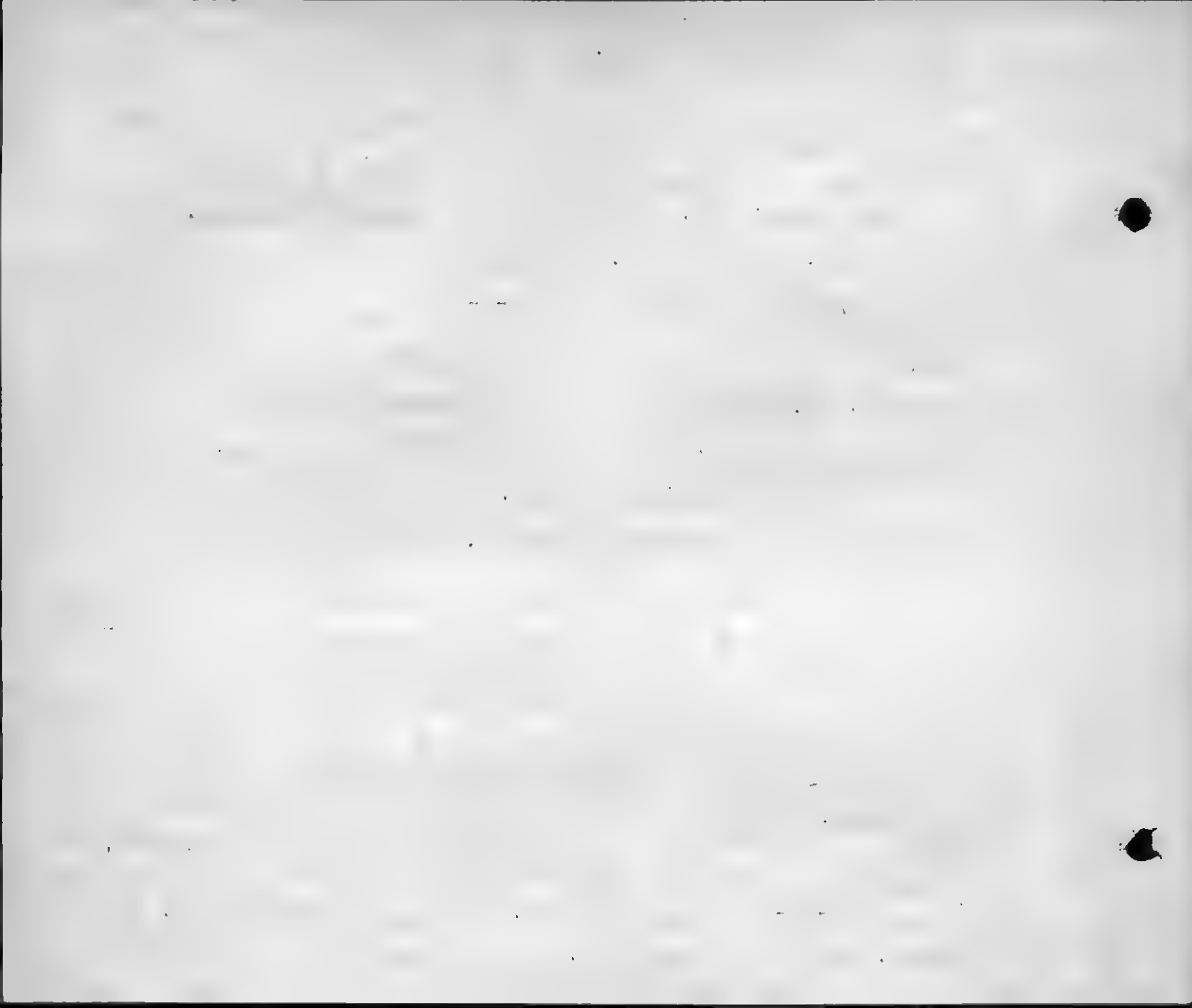


1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Eas 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Baltimore b. COUNTY Maryland | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 445 Sunshine Rd. | | d. STREET ADDRESS 304 3rd St. Overlea | |
| 3. NAME OF DECEASED (Type or print) JOSEPH D. WEBSTER | | 4. DATE OF DEATH Month OCTOBER Day 14 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-4-1908 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George R. Webster | | 14. MOTHER'S MAIDEN NAME Florence Bramble | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) same | | 16. SOCIAL SECURITY NO. 216035172 | |
| 17. INFORMANT Elaine Webster | | Address same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO (b) Generalized metastasis. DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Wm. J. Ruck M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DATE SIGNED October 14, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 10-17-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park | | 22d. LOCATION (City, town, or country) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Rd. | | 24a. REC'D BY REGISTRAR OCT 18 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

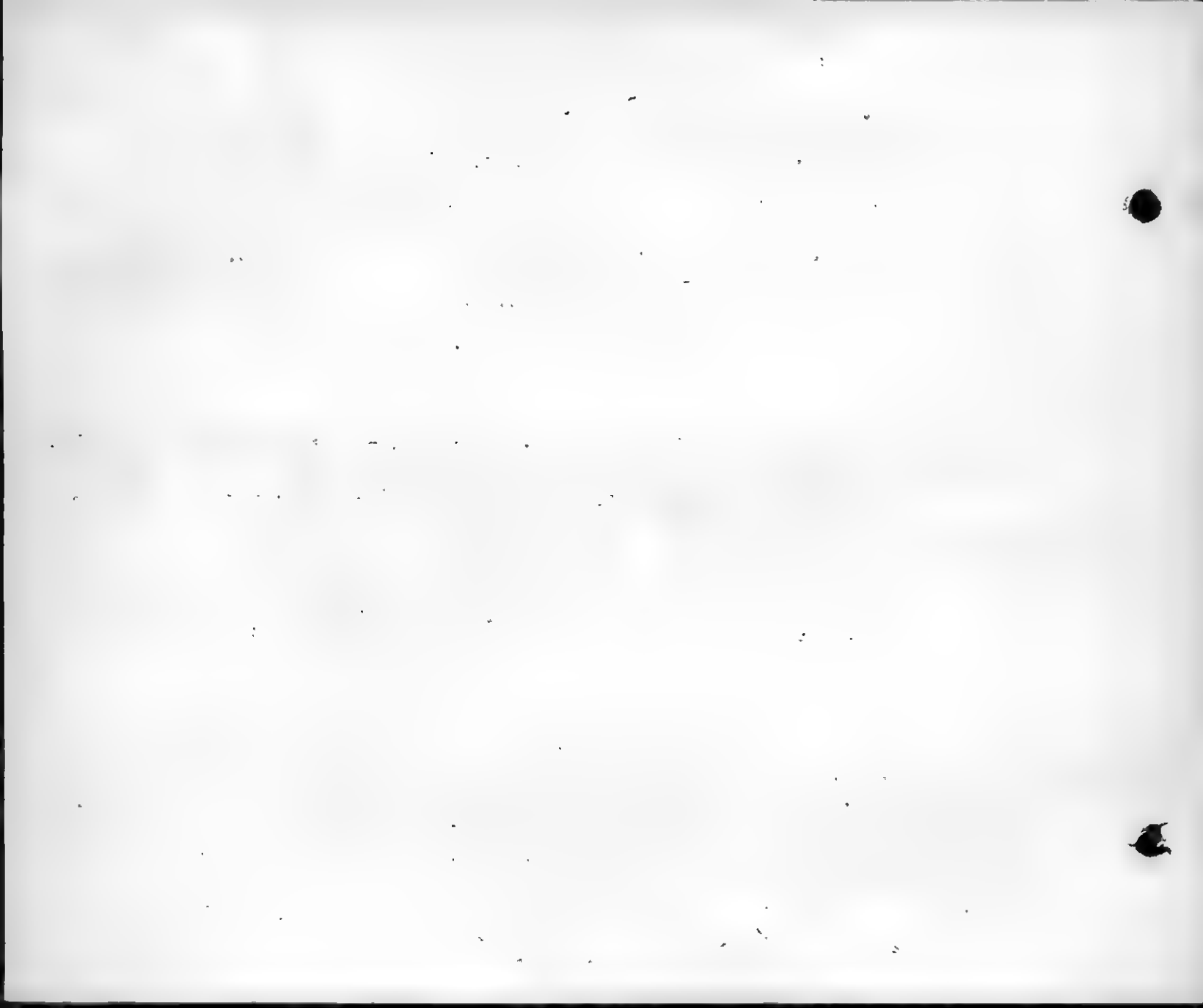
111198

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

111182
Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | c. LENGTH OF STAY IN 1b Pikesville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Purvis Place | | d. STREET ADDRESS 204 Purvis Place | |
| 3. NAME OF DECEASED (Type or print) First MARCUS Middle HESS Last WEIL | | 4. DATE OF DEATH Month Oct. Day 26 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 6, 1880 |
| 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min 79 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker | | 10b. KIND OF BUSINESS OR INDUSTRY Self | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? Ohio | |
| 13. FATHER'S NAME Moses Weil | | 14. MOTHER'S MAIDEN NAME Sarah Hess | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Nettie Weil-204 Purvis Place-Pikesville | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO (b) few yrs. Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. DUE TO (c) mixed tumor of rt. parotid gland removed 5 Oct 60 | | INTERVAL BETWEEN ONSET AND DEATH few yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1958 , 19 25 Oct , 19 25 Oct , 19 25 Oct , that I last saw the deceased alive on 25 Oct , 19 60 , and that death occurred at 1 P. M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Paul H Royse | | DATE SIGNED 27 Oct 60 | |
| PHYSICIAN'S NAME (Type) Paul H Royse MD | | ADDRESS (Street, city or town, state) Pikesville 8 Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/28/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Oheb Shalom Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker | | 24. REC'D BY REGISTRAR 17 Md. | |
| 25. ADDRESS North & Palmer Balt- | | 26. REGISTRAR'S SIGNATURE Arthur S. Threlk | |



11199

CERTIFICATE OF DEATH

11183

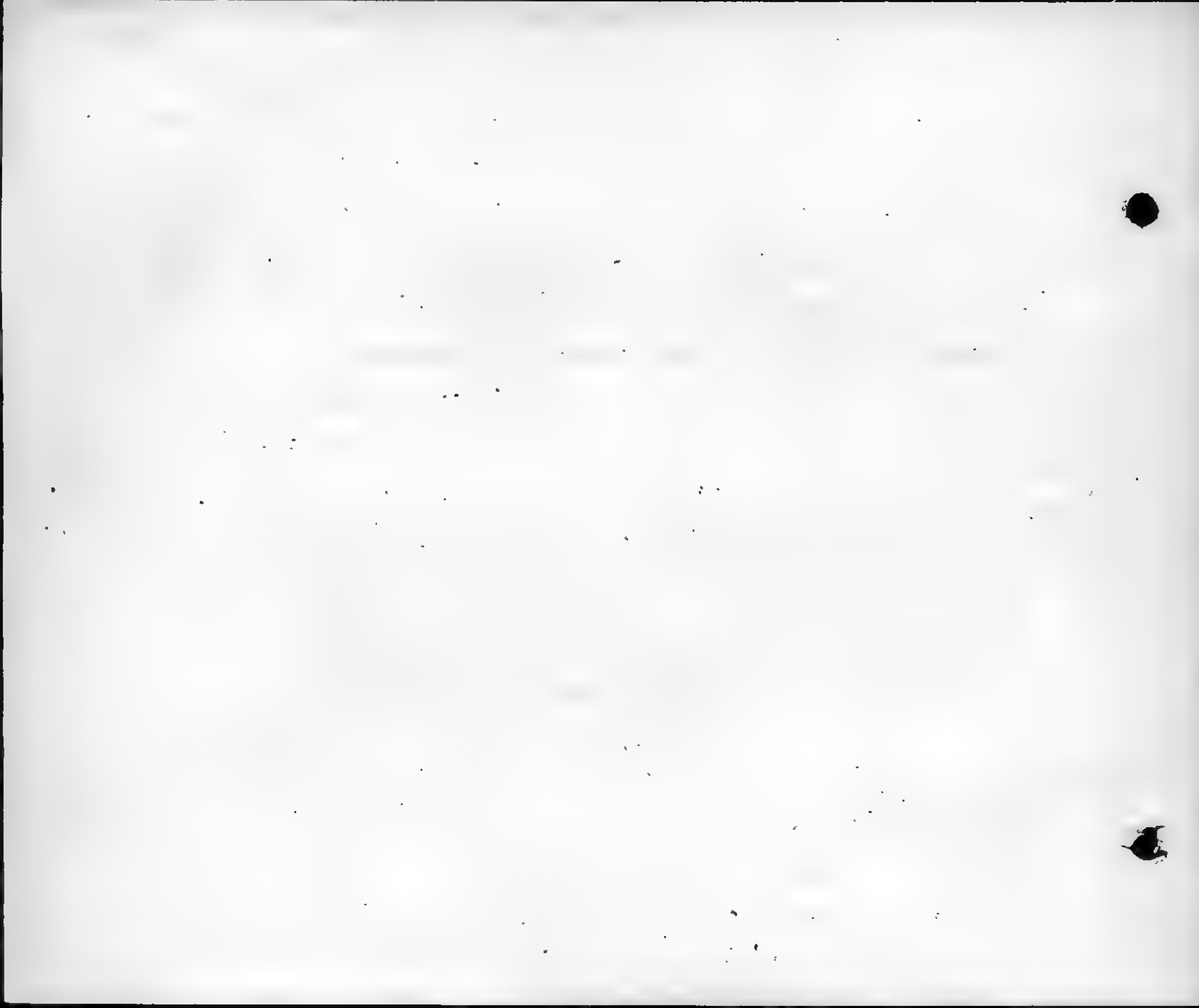
Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESACO | | c. LENGTH OF STAY IN 1b LIFE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8415 OLD PHILA ROAD. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BERTHA Middle A. Last WIEGAND. | | 4. DATE OF DEATH Month DEC Day 26 Year 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC 10, 1897 |
| 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 12. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | |
| 13. BIRTHPLACE (State or foreign country) MARYLAND | | 14. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. FATHER'S NAME JOHN. BOHLEN. | | 16. MOTHER'S MAIDEN NAME MARY E MOHR. | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 18. SOCIAL SECURITY NO. NONE. | |
| 19. INFORMANT MARIE LAUBACH. | | Address 8415 OLD PHILA. RD. | |
| 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-Vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic Cardio-Vascular disease DUE TO (b) Sudden DUE TO (c) 2 yrs | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 22c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 22d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 22f. (City or town) (County) (State) | |
| 23. I certify that I attended the deceased from Jan 1, 1960 to Oct 6, 1960 that I last saw the deceased alive on Oct 6, 1960 and that death occurred at 3 P. M. from the causes and on the date stated above. | | 24. ADDRESS (Street, city or town, state) Balto 6 Md | |
| 25. ACTUAL SIGNATURE J M Baumgardner M.D. | | 26. DATE SIGNED 10/9/60 | |
| 27. PHYSICIAN'S NAME (Type) | | 28. ADDRESS (Street, city or town, state) | |
| 29a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 29b. DATE THEREOF OCT 10, 1960 | |
| 29c. NAME OF CEMETERY OR CREMATORY ZION LUTHERAN | | 29d. LOCATION (City, town, or county) (State) Stemmers Run Md. Md | |
| 30. FUNERAL DIRECTOR'S SIGNATURE Jessie E. Funeral Home | | 31. ADDRESS 7401 Belair Rd #6 | |
| 32. REC'D BY REGISTRAR 14 '60 | | 33. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
TSM 9/58



1 *P* *50* *I* *2*

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

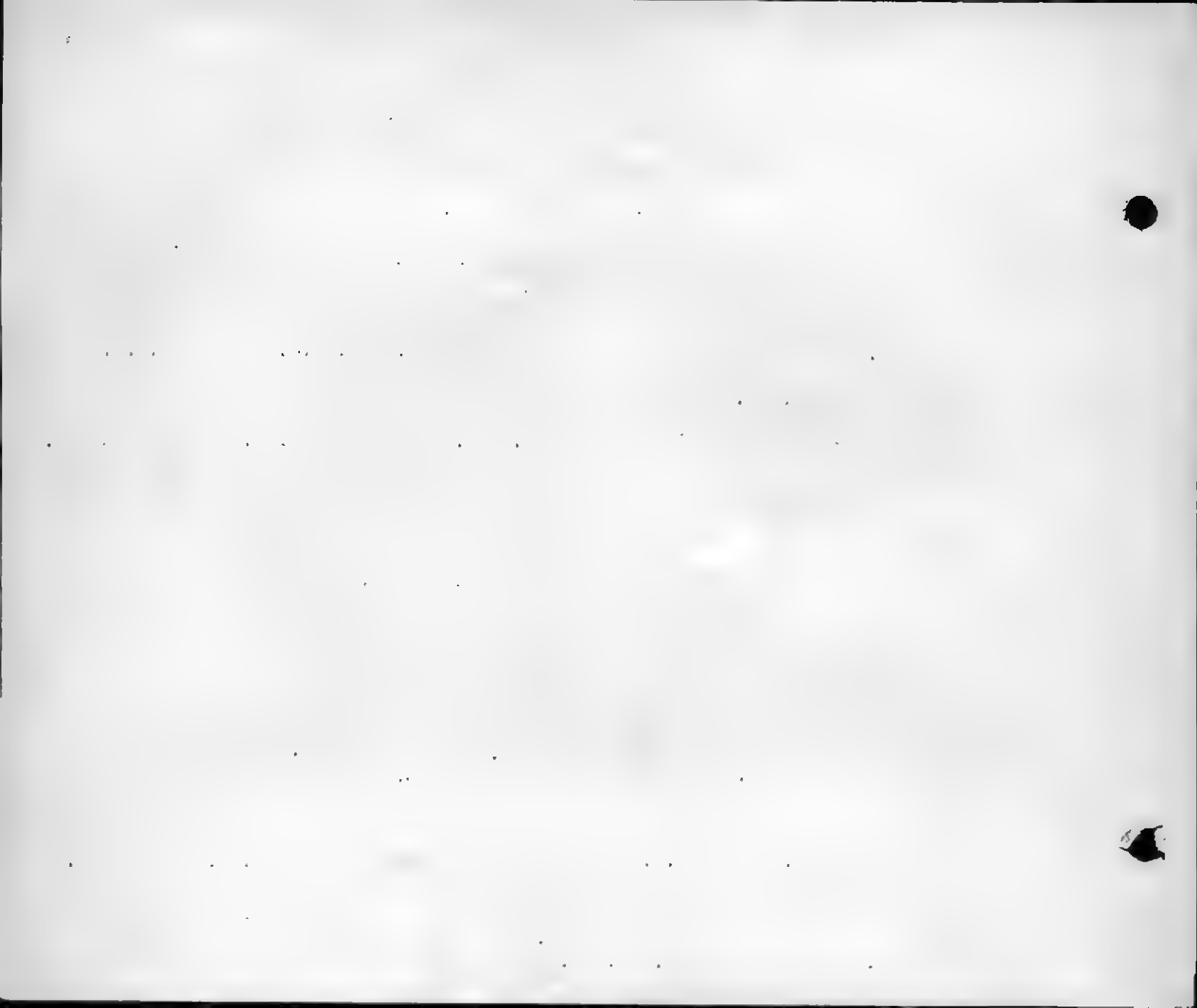
VR A15 (4)
15M 9/59

11200

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12390

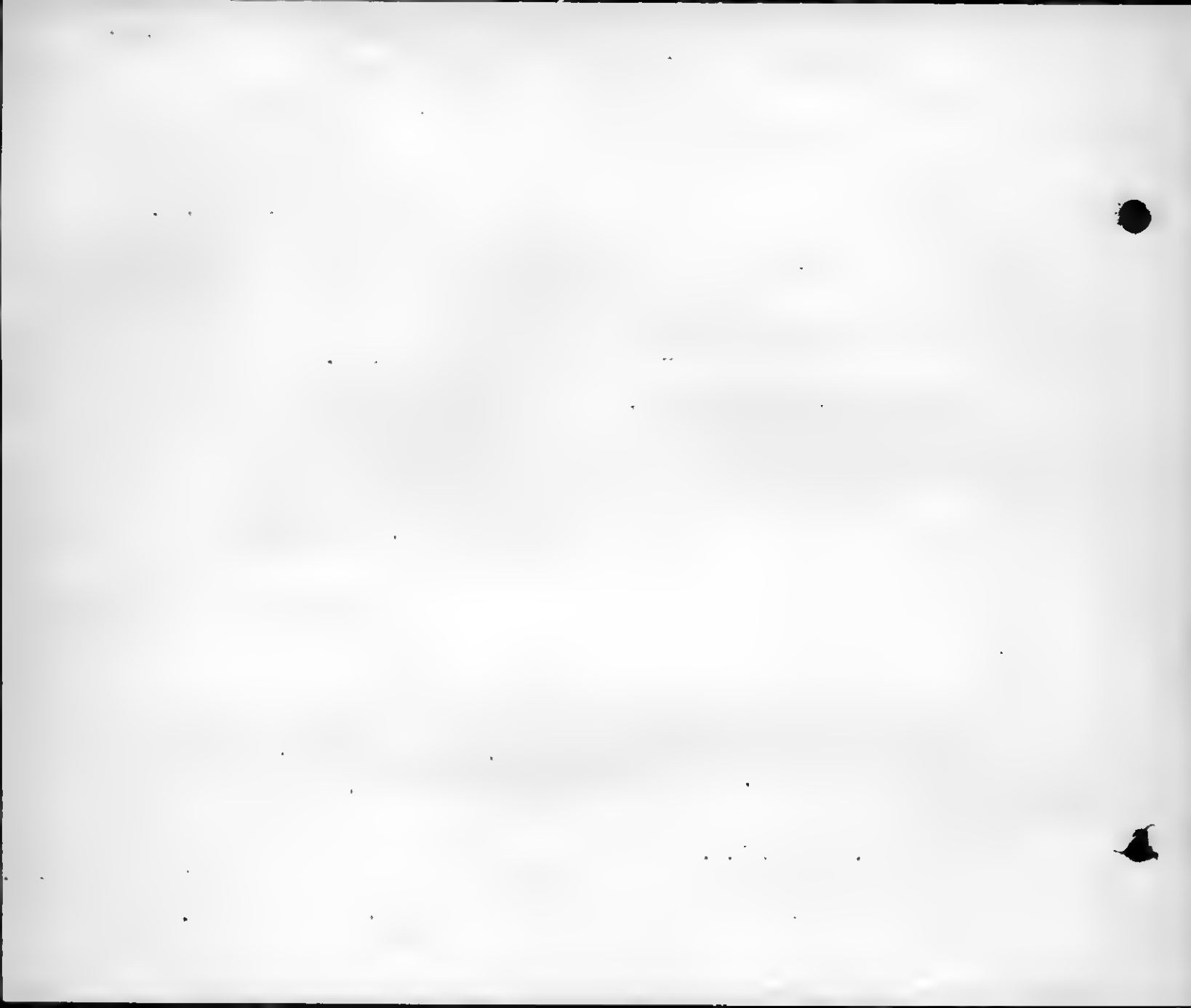
| | | | | | | | |
|---|---|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland | | | | c. LENGTH OF STAY IN 1b 8 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vet. Adm. Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle -- Last WILLIAMS, JR. | | | | 4. DATE OF DEATH Month October Day 29 Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 23, 1924 | 9. AGE (In years last birthday) 36 yrs | IF UNDER 1 YEAR Months 3 Days 01 | IF UNDER 24 HRS Hours 00 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking | | 11. BIRTHPLACE (State or foreign country) Fayetteville, N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert Williams, Sr. | | | 14. MOTHER'S MAIDEN NAME Flora McPherson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO PL-28 K 0846-10-3634 | | 17. INFORMANT Clin. Rec. VAH, Baltimore, Md. Fort Howard Div. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS | | | | | | 6 hours | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HODGKIN'S DISEASE | | | | | | 2 years | |
| (c) HEMORRHAGIC DIATHESIS DUE TO DG.# 2 | | | | | | 1 week | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that ID (this hospital) attended the deceased from Oct. 21, 1960 to Oct. 29, 1960 , that I (we) last saw the deceased alive on Oct. 29, 1960 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Norman P. Jones | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) NORMAN P. JONES, M.D. | | 22d. ADDRESS VAH, Baltimore 18, Md. Ft. Howard Div. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11/1/60 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips | | ADDRESS 1808 N. Monroe St. Balto. 17, Md. | | 25a. REC'D BY REGISTRAR DATE NOV 9 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



11201



| | | | |
|---|--|--|--|
| PLACE OF DEATH a. COUNTY MARYLAND | | USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) 2. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mark Middle Evan Last WINCHESTER | | 4. DATE OF DEATH Month 10 Day 20 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/4/60 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- | | 9b. KIND OF BUSINESS OR INDUSTRY --- | 9c. BIRTHPLACE (State or foreign country) Baltimore, Md. |
| 10. FATHER'S NAME Robert Jennings Winchester, Jr. | | 11. MOTHER'S MAIDEN NAME BLACKMON, Valinda | |
| 12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 13. SOCIAL SECURITY NO. np | |
| 14. INFORMANT Rosewood records | | Address --- | |
| 15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status epilepticus 750 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anencephaly with encephalocele - occipital DUE TO (c) --- | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 17, 1960 to Oct. 20, 1960 that (I) (we) last saw the deceased alive on Oct. 20, 1960 and that death occurred at 3:10 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Harry J. Butler, M.D. | | 22b. DATE SIGNED 10/21/60 | |
| 22c. PHYSICIAN'S NAME (Type) Harry J. Butler, M.D. | | 22d. ADDRESS Rosewood State Training School, Odessa | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 10/21/60 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Cem. | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co | | 24a. ADDRESS 4905 York Rd | 24b. REC'D BY REGISTRAR DATE 10/24/60 |
| 24c. REGISTRAR'S SIGNATURE Wm. J. Evans | | 24d. REGISTRAR'S SIGNATURE --- | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

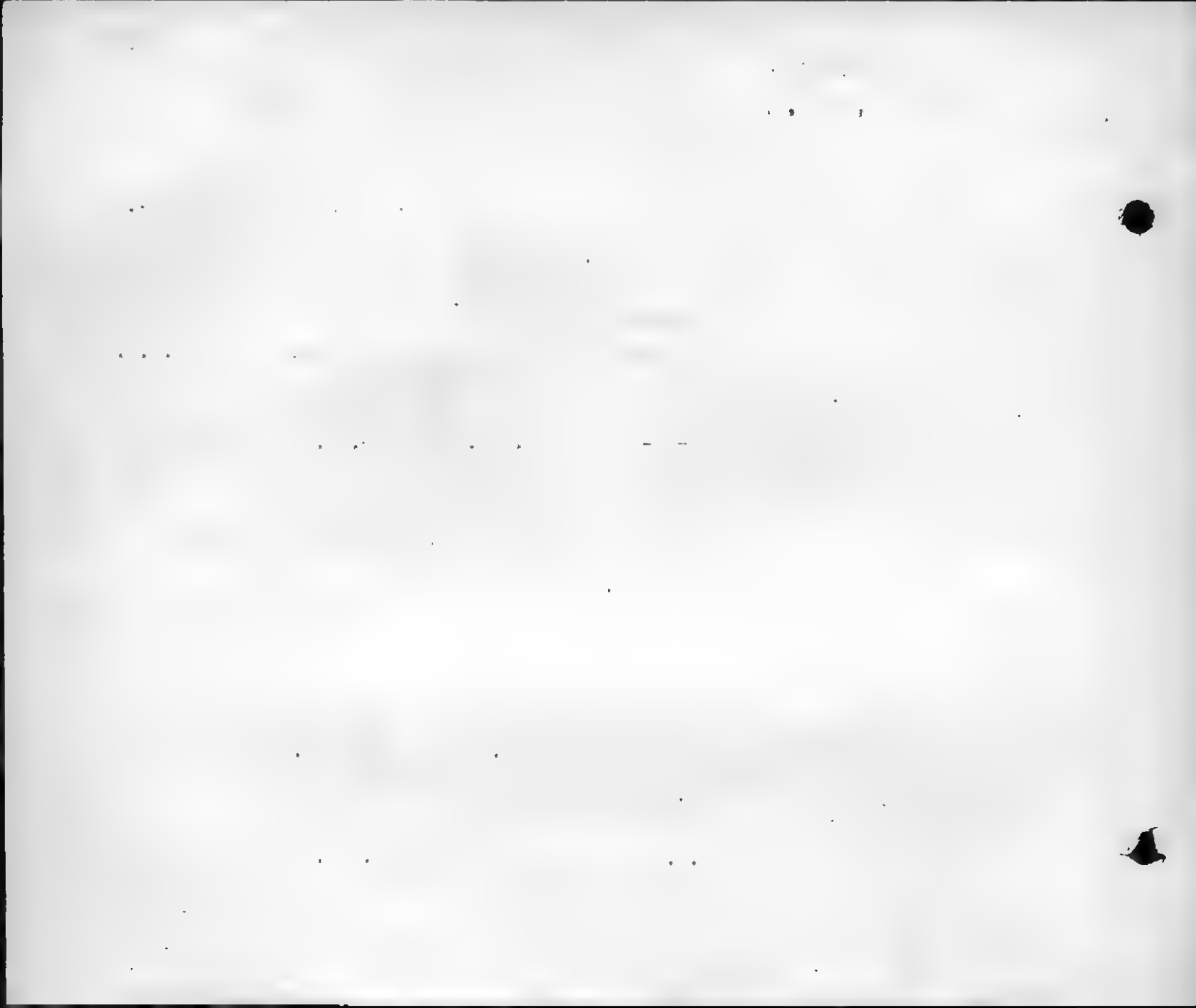
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11202

11185

| | | | | | | | |
|---|---------------------------------|--|-----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 21 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS RFD #1, Box 401, Ridgeway Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First DANIEL Middle E. Last WISNER | | | | 4. DATE OF DEATH Month OCTOBER Day 17 Year 1960 | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/5/11 | | 9. AGE (In years last birthday) 49 yrs. | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Building | | 11 BIRTHPLACE (State or foreign country) Rayville, Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Edward Wisner | | | | 14 MOTHER'S MAIDEN NAME Ida Still | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 180-09-4249 | | 17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE ORAL HEMORRHAGE 141.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EPIDERMOID CARCINOMA OF THE TONGUE WITH METASTASIS (c) TO CERVICAL LYMPH NODES EDEMA OF LUNGS | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 1 YEAR | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 26 , 1960, to Oct. 17 , 1960, that (I) (we) last saw the deceased alive on October 17 , 1960, and that death occurred at 12:20 PM on the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Joshua D. Smith | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 10/17/60 | |
| 22c. PHYSICIAN'S NAME (Type) JOSHUA SMITH, M.D. | | | | 22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 20, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Stablers Cemetery | | 23d. LOCATION (City, town, or county) (State) Parkton, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein, New Freedom, Pa. | | | | 25a. REC'D BY REGISTRAR OCT 20 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |



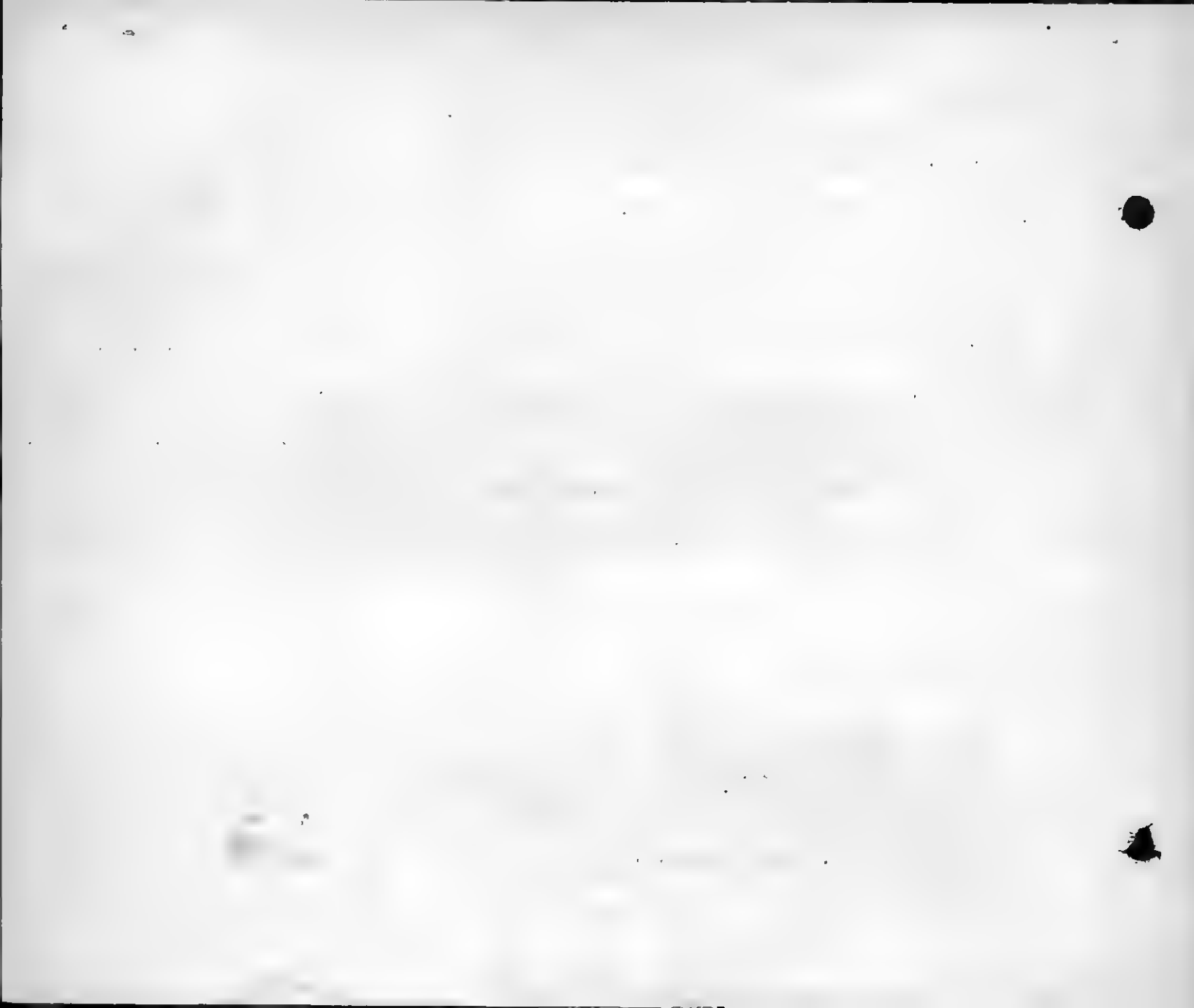
may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11203 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11186

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 4 Days | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 3350 Strickland Street, (29) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CARROLL L. WOODY | | | | 4. DATE OF DEATH Month Day Year October 4 1960 | | | |
| 5 SEX Male | | 6 COLOR OR RACE White | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH January 27, 1897 | |
| 9. AGE (In years last birthday) 63 | | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS Months Days Hours Min | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Material Handler | | | | 10b. KIND OF BUSINESS OR INDUSTRY Plate Glass | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME John D. Woody | | | | 14. MOTHER'S MAIDEN NAME Margaret M. Davidson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 213-05-2955 | | 17. INFORMANT Address Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4225 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from Sept. 30 1960 to October 4 1960 , that (if we) last saw the deceased alive on October 4 1960 , and that death occurred at 8:35 A. M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Frederick S. Donaldson | | | | 22b. DATE 10/4/60 | | 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/7/1960 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cpn | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE St. Gorman Schwal | | | | 25a. REC'D BY REGISTRAR DATE OCT 6 '60 | | 25b. REGISTRAR'S SIGNATURE Robert S. Kline | |

3512 Fred. Ave. - 29-



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

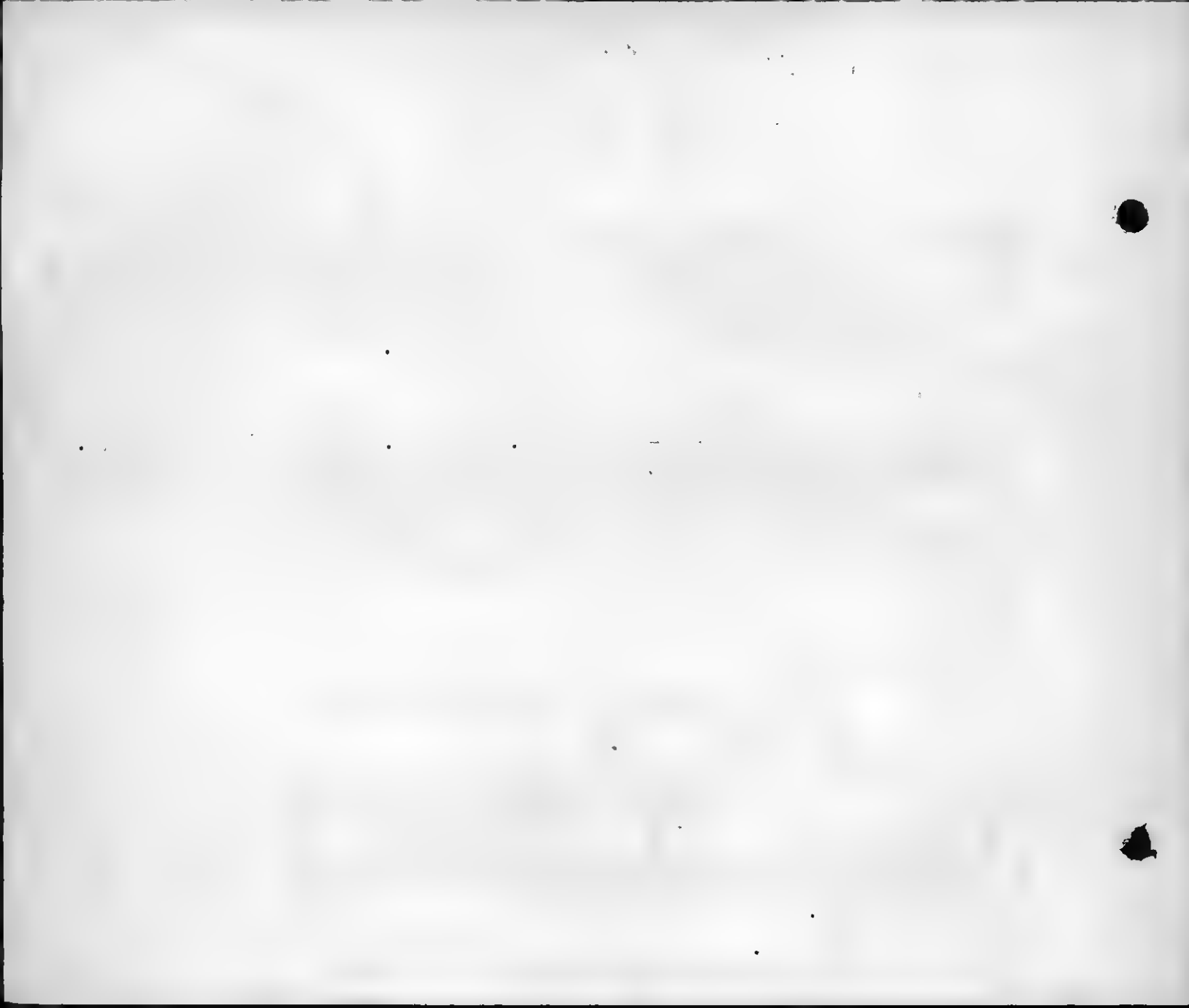
11204

CERTIFICATE OF DEATH

11187

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> -b COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4 (Towson)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson, Baltimore 4 Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Miller Road</u> | | d. STREET ADDRESS <u>61 Miller Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EDWARD</u> Last <u>YEAPLE</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 3, 1901</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Eastman Kodak</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jm.H. Yeaple</u> | | 14. MOTHER'S MAIDEN NAME <u>Robert Perry</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO <u>313-01-2709</u> | |
| 17. INFORMANT <u>Mrs. Marion F. Yeaple</u> | | Address <u>61 Miller Road, 4</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung-Rt.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>60</u> , to <u>Oct 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>60</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Laurence C. Post</u> | | ADDRESS (Street, city or town, state) <u>6805 York Rd Baltimore 12 Md</u> | |
| PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u> | | DATE SIGNED <u>10/10/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct. 13, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery, Baltimore, Md.</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.</u> | | 24. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u> | |
| ADDRESS <u>700 York Rd. Towson, Md.</u> | | DATE <u>OCT 13 '60</u> | |



11205

11188

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 20 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6419 Murray Hill Rd. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore f. STREET ADDRESS 3913 Bonner Road | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Frances T. Young | | 4. DATE OF DEATH Month Day Year October 13, 1960. | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 23, 1877 |
| 9. AGE (In years last birthday) yrs. 82 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Michael C. Gunning | | 14. MOTHER'S MAIDEN NAME Elizabeth C. Pierce | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Edward T. Young | | Address 405 Meadow Rd. (6) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 443x DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) person DUE TO (c) person | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 1/2 yr | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema due to Cardiac Decompensation | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ** | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 4, 1944 to Oct 13, 1960 that I last saw the deceased alive on Oct 12, 1960 , and that death occurred at 11:45 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED 10/14/60 | |
| ACTUAL SIGNATURE Lester N. Kolman M.D. | | | |
| PHYSICIAN'S NAME (Type) LESTER N. KOLMAN, M.D. | | 3700 Park Heights Avenue | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10-17-1960 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park | |
| 22d. LOCATION (City, town, or county) (State) Baltimore Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong | | ADDRESS 3207 W. North Ave | |
| 24a. REC'D BY REGISTRAR DATE OCT 17 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon/paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11206

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11189

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 2mth6dys | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle M Last Zayenkauskas | | | | 4. DATE OF DEATH Month 10 Day 9 Year 1960 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 16, 1885 | |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months 10 Days 9 Hours 19 Min. | | IF UNDER 24 HRS. Hours 19 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailoring | | | | 10b. KIND OF BUSINESS OR INDUSTRY tailoring Co. | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 12. CITIZEN OF WHAT COUNTRY? Lithuania ✓ | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | | | | 16. SOCIAL SECURITY NO. 213-09-9129 | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BACTEREMIA FROM MULTIPLE DECUBITUS DUE TO GENERAL DEBILITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERAL DEBILITY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1960 to OCT 9, 1960 , that (I) (we) last saw the deceased alive on OCT. 9, 1960 , and that death occurred at 2200 M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE P. K. Yon Yip | | | | 22b. DATE SIGNED 10/9/60 | | 22c. PHYSICIAN'S NAME (Type) P. K. Yon Yip | |
| 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| Burial | | 10/13/60 | | Holy Redeemer Com. | | 4430 Belair Rd Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Cavanaugh | | | | 25a. REC'D BY REGISTRAR Hollis St. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

1150

STATE OF TEXAS

1150

(M)

(P)

(P)

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|--|--|----------------------------------|---|--|---|---|---|---|------------------------------|--|--|
| 11207 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 11190 Reg. Dist. No. | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City | | | d. STREET ADDRESS 414 Frederick Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARY CATHERINE ZENTER | | | | | 4. DATE OF DEATH Month Day Year Oct. 19, 1960 19 | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-12-1874 | | 9. AGE (In years last birthday) yrs. 86 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | 11. BIRTHPLACE (State or foreign country) Montgomery Co. Md | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Richard Burriss | | | | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth Cracroft | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. ? | | | | | INFORMANT Address Dudley Zenter, 414 Frederick Road, Ellicott City | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from April , 19 60 , to Oct 19 , 19 60 , that I last saw the deceased alive on Oct 18 , 19 60 , and that death occurred at 10 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| ACTUAL SIGNATURE Robert B. Taylor M.D. | | | | | ADDRESS (Street, city or town, state) 111 Columbia Rd Ellicott City Md | | | | | DATE SIGNED 10-20-60 | |
| PHYSICIAN'S NAME (Type) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 22b. DATE THEREOF 10-22-60 | | 22c. NAME OF CEMETERY OR CREMATORY Union | | | 22d. LOCATION (City, town, or county) (State) Rockville, Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md | | | | | 24a. REC'D BY REGISTRAR DATE OCT 24 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Ryan | | | | |

